

KIA PUAWAI

National SUDI Prevention Programme
Evaluation: Final Evaluation Report

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MANATŪ HAUORA

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Tēnei te tino mihi ki ngā pou kaha o tēnei kaupapa a SUDI, otirā ki ngā kaimahi e mahi ai i ā rātou wāhi mahi katoa o SUDI, mō ā rātou manaaki mai ki *Te Werohau* mō tēnei pūrongo. We wish to thank our evaluation participants from across the SUDI prevention space for contributing their time and energy to this evaluation. Ngā mihi maioha ki a koutou katoa.

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Te harakeke

The cover page, of harakeke, commonly symbolises whānau, with the rito (*root, centre*) representing baby, encircled by older fronds for protection.¹ Given the relevance of this metaphor to SUDI prevention, we adopted it as our front image.

Te Werohau

Te Werohau is the Research and Evaluation unit of Te Whare Wānanga o Awanuiārangi. We work for government agencies and other service providers, to find out what services work well, for whom, and under what conditions. We are leaders in kaupapa Māori evaluation, and leverage our cultural insights and principles to inform processes across all of our mahi. ‘Werohau’ are wispy, feathery clouds found in the upper levels of Ranginui’s realms. At the whim of the clemency and inclemency of high altitude weather, werohau are cloud formations that signal change on the horizon. Te Werohau embodies this metaphor: driven by kaupapa Māori, and with Māori voices at our centre, we support organisations to listen to the wind, watch the movements of the clouds, and navigate through with confidence and strength.

¹ See Andrea Watson, 2020, ‘Pā harakeke as a research model of practice’. *Aotearoa New Zealand Social Work*, 32, 3, p. 31.

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Executive Summary

This report presents the findings of *Kia Puawai*, the Ministry of Health's (the Ministry) kaupapa Māori evaluation of the National Sudden Unexpected Death in Infancy (SUDI) Prevention Programme (NSPP). The NSPP is the latest iteration in a series of SUDI-prevention initiatives, emergent from the success of earlier kaupapa such as the Sudden Infant Death Syndrome (SIDS) Prevention programme. However, Māori, Pasifika, and other priority populations continue to disproportionately experience SUDI. The Ministry commissioned *Kia Puawai* to explore the effectiveness of the NSPP, and how it can be improved to better address these inequities.

Representatives from a number of key groups and organisations were interviewed for this evaluation. They include:

- The Ministry;
- District Health Boards (DHBs);
- NSPP Regional Coordinators;
- Safe Sleep Coordinators;
- The National SUDI Prevention Coordination Service; and
- The SUDI Prevention Expert Advisory Group.

Seventy-three suitable participants from across these organisations were identified, with our team conducting 54 interviews across September and October 2021. Data collected was then thematically analysed, and assessed against key evaluation criteria and performance indicators, to determine the evaluation findings.

Overall, there remains a palpable conviction and passion for this mahi amongst those we spoke with, and there have been isolated examples of success in mitigating SUDI. In general, there is clear commitment by the sector, and groups involved, to work towards addressing inequity in SUDI. But this is clouded by larger structural issues with the NSPP. ***Kia Puawai's* central finding is that the current design of the NSPP is incohesive, lacks coordinated, systems leadership, and strategic direction across the key kaupapa partners,² and fragments SUDI-prevention investment into partitioned, siloed areas.³** This is exacerbated by an 'outputs rather than outcomes' focus of the programme, which significantly limits the effectiveness of the NSPP.

² 'Kaupapa partners' denotes all participants involved in this evaluation, and as a kaupapa Māori organisation, we use this term instead of 'stakeholders'. The latter refers to the colonial process of 'staking' claim to Indigenous whenua, irrespective of tangata whenua and Indigenous sovereignties. Words matter, because of the baggage they bring with them; hence 'kaupapa partners' instead.

³ See also Department of Prime Minister and Cabinet, 2021, *Response to the Health And Disability System Review / Hauora Manaaki ki Aotearoa Whānui*, which highlighted the fragmented nature of the health and disability system. Available at <https://dpmc.govt.nz/sites/default/files/2021-03/cabinet-material-health-disability-system-review-mar21.pdf>, p. 2 [DPMC, 2021a].

Based on these findings, we have developed the following recommendations to reset the NSPP, and provide a more integrated, cohesive programme that better delivers for Māori, Pacific, and priority populations, in pursuit of pae ora. They include:

1. Initiating a complete programme refresh of the NSPP, codesigned with Māori and Pasifika whānau and health leadership. Based on the findings in this evaluation, we suggest the refresh incorporates both national governance and local-level delivery of NSPP services into a single framework. This would include:
 - a. National governance, administered by a national entity/agency to manage and oversee the overall coordination and strategic direction of the NSPP. This agency would ensure integration of the various SUDI prevention-related services (SRS), both within the health sector (such as the WCTO ecosystem), and outside of it (such as Kāinga Ora, Oranga Tamariki, the Ministry of Education, the Ministry of Social Development, Te Puni Kōkiri, the Ministry for Pacific Peoples, and so forth), into a cohesive platform. The entity would also track progress towards Pae Ora, equity, sustainability, and so forth;^{4,5} and
 - b. Localised coordination, oversight, and delivery of SUDI prevention-related services at a community level, working in concert with the national entity. This would replace and amplify the former Regional Coordination role, and ensure the programme is grounded within the community itself, and seen as legitimate in the eyes of whānau, hapū, and iwi. Without this legitimacy and mana, the programme will see limited success. Co-design will inform how communities envision this unfolding.

This refresh should also:

- a. Be grounded by Te Tiriti o Waitangi, and kaupapa Māori and Pasifika-based principles.
- b. Meaningfully demonstrate partnership by prioritising Māori and Pasifika leadership.
- c. Ensure the SUDI-prevention workforce is culturally competent and able to work appropriately with, and are acceptable to, Māori and Pasifika whānau.

⁴ It is possible this role could be incorporated into the forthcoming Health New Zealand or Māori Health Authority (see <https://dpmc.govt.nz/sites/default/files/2021-04/htu-factsheet-hauora-maori-en-apr21.pdf>).

⁵ As emphasised in the *Health and Disability System Reform: Making a stronger health and disability system for all New Zealanders*. Department of Prime Minister and Cabinet, April 2021, available at <https://dpmc.govt.nz/sites/default/files/2021-05/health-reform-white-paper-summary-easy-may21.pdf>, pp. 5-9 [DPMC, 2021b].

- d. Reallocate all SUDI-prevention investment into the national agency, devolving the current funding arrangements to do so, to avoid the current fragmented nature of investment. This is to ensure contracting models are sufficient and flexible to advance equity for whānau Māori, Pasifika and other priority populations, from a centralised viewpoint. The current NSPP related service configurations are not congruent with government direction and policy guidance for Te Tiriti.
 - e. Disestablish the Regional Coordinator roles as they currently are, in giving way to this new model.
 - f. Remain whānau-centric, to ensure care is person- and whānau-centred, and be integrated into grassroots communities (through churches, marae, schools, Kōhanga Reo, Kura Kaupapa, Wharekura, etc.).
 - g. Clearly communicate the new roles and responsibilities of the refreshed NSPP to the health and related sectors, so everyone knows ‘who does what’.
 - h. Improve, strengthen, and streamline SUDI-related data access and distribution.
2. Prioritising the continued maintenance of relationships and trust established thus far with the maternity health sector, especially with Māori providers, as the refresh proceeds. This is critical – there can be no disruption to these relationships, as was the case in the interval between SIDS and the NSPP, because of the negative impacts that would likely arise.
 3. Having a centralised, coordinated approach for the management and dissemination of key messages, advice, and related SUDI-prevention queries. This would sit within the centralised entity, and be based on the principles outlined on pp. 36-7.

KIA PUAWAI

Evaluation of the National SUDI Prevention Programme

Background to the kaupapa

The Ministry of Health's (Ministry) review of Well Child Tamariki Ora (WTCO) identified the programme's contribution to the health and wellbeing of many tamariki. However, inequities remain for tamariki Māori and Pasifika, tamariki with disabilities, and tamariki in state care and/or with high needs. The continued inequity suffered by whānau Māori and whānau Pasifika in Sudden Unexpected Death in Infancy (SUDI) is one such critical area requiring attention. While SUDI rates for non-Māori and non-Pasifika are falling, Māori and Pasifika rates far outstrip these. With New Zealand's SUDI rates among the highest in the world, this is an urgent area of concern. These inequities are distressing, especially given the Ministry's significant investment in reducing smoking in pregnancy, and bed sharing, the two key modifiable risk factors the NSPP targets. The National SUDI Prevention Programme (NSPP)⁶ is a national intervention to this. It is the latest iteration in SUDI interventions, emergent from earlier kaupapa such as the Sudden Infant Death Syndrome (SIDS) Prevention programme in the early 1990s.

The NSPP's overall goal is to reduce the incidence of SUDI to 0.1 in 1000 infants by 2025. The current design of the programme is comprised of three key service components, who are the primary kaupapa partners⁷ in the NSPP. They include the District Health Boards (DHBs), whose work involves employing Safe sleep coordinators and distributing Infant Safe Sleep Beds (ISSBs); Regional Coordinators, who support the DHBs and SUDI prevention-related work in their regions; and National SUDI Prevention Coordination Service (NSPCS), who provide support both to DHBs and Regional Coordinators in a national coordination service. Their work and delivery rely heavily on collaboration with services outside of this structure, but still within the maternity and child health sector (i.e., intra-sectoral service integration). This is distinct from SUDI prevention-related services (SRSs), which are any service delivered/funded from sources outside the SUDI Prevention budget (such as maternity and stop-smoking services). Other kaupapa partners in this evaluation include:

- The Ministry
- The SUDI Prevention Expert Advisory Group (EAG)

⁶ 'NSPP' is used in this evaluation to refer to the main components of the programme: DHBs, the National SUDI Prevention Coordination Service, Safe Sleep Coordinators, and Regional Coordinators.

⁷ As earlier, 'kaupapa partners' refers to participants and those with vested interests or responsibilities in the NSPP.

Kia Puawai: this evaluation

This report is the result of the 2021 kaupapa Māori evaluation of the NSPP. It combined both process and formative focuses, and evaluated the delivery and effectiveness of the various components of the NSPP, and its inter-sectoral linkages and integration. It sought to identify improvements for the programme, as an integrated component of the wider maternity and child health landscape, and how to better address the continued inequity in SUDI rates experienced by Māori and Pasifika peoples.

Te Werohau, of Te Whare Wānanga o Awanuiārangi, was commissioned to lead the evaluation. As a kaupapa Māori evaluation team, we are guided by the principal whakataukī,

Poipoia te kākano kia puawai | Nurture the seed and it will blossom

This whakataukī insists that direction, activity, and responses centre both on the wellbeing of our tamariki, and the collective responsibility we share in nourishing our pēpi to blossom into rangatira. ‘Poipoia te kākano’ is the principal whakataukī used by WCTO, and we have adopted it here to reflect the need for SUDI prevention to align, and be better integrated with, a wider early years programme in future.

As we proceed in our work, our overarching provocation for all kaupapa partners is, ‘How do you realise the fulfilment of ‘Poipoia te kākano kia puawai’ in your mahi?’ We have adopted the latter phrase of the whakataukī, ‘kia puawai’, as our title for this evaluation, in emphasising prosperity and success in maternal health. In addition to ‘poipoia’, the key population outcomes of relevance to the NSPP are:

1. Māori live longer, healthier, and more independent lives
2. New Zealanders have equitable health status

Methodology

Kia Puawai was largely qualitative-based, conducted through an initial document review, followed by a number of in-depth interviews with kaimahi (*staff, workers*) of kaupapa partners. The evaluation was guided by an Evaluation Framework, developed and co-designed with the Ministry of Health, which included overarching Key Evaluation Questions (KEQs), and rubrics with criteria and performance indicators (see below). The Evaluation Framework was grounded in the Ngā Pou o Well Child Tamariki Ora Framework (Ngā Pou). Those pou include:

- **Te Tiriti o Waitangi (Te Tiriti)**

- Realising the principles of tino rangatiratanga, equitable outcomes, active protection, partnership, and adequate resourcing of kaupapa Māori services.
- **Achieving equity (Equity)**
 - Ensuring the system itself supports equity in outcomes and resource allocation for priority populations.
- **Pae ora – Healthy futures (Pae ora)**
 - Enable whānau, especially for priority populations to express and achieve their aspirations in health for their tamariki.
- **Ways of working**
 - The ethics and values of manaaki, kaitiaki, whakapono, and kōkiri ngātahi guide our approach to engagement.

The framework was organised according to the first three pou above, and is attached as Appendix 1. The last pou, ways of working, supplemented our kaupapa Māori approach to engagement with service providers, DHBs, and so forth.

Data collection instruments such as interview guides (attached in Appendix 2) were developed to gather data under these KEQs and performance indicators. These were reviewed and adapted with Ministry leads in conjunction with *Te Werohau*. Key data sets for this evaluation include interviews with:

- Ministry of Health leads for NSPP services;
- DHBs;
- Regional Coordinators;
- Safe Sleep coordinators;
- the NSPCS; and
- the EAG.

Seventy-three suitable participants were identified, and engagement with them began in August 2021. As we progressed, this list was refined in light of personnel and role changes, and updated in conjunction with the Ministry. Through multiple means, we then reached out to 68 of these participants (the initial reach-out emails are attached in Appendix 3). From this, a total of 54 interviews were conducted over September and October 2021. The collected data was then analysed thematically, and assessed against key evaluation criteria and performance indicators, to determine the evaluation findings.

Key Evaluation Questions

The following Key Evaluation Questions (KEQs) address the core scope of this evaluation. The overarching question for this evaluation is, ‘To what extent are the existing services/programme efforts of NSPP contributing to ‘Poipoiā te kākano kia puawai’? The below KEQs respond to this overall frame:

1. To what extent does the content, design, and delivery of NSPP and SUDI prevention-related services (SRSs) meet the needs of Māori, Pasifika, and other priority populations?

- a. In what ways are whānau Māori and whānau Pasifika supported to access, engage, and utilise NSPP services and SRSs?⁸
- b. What is working well, for whom and in what ways? What can be improved?

2. What is the quality of the relationships between the NSPP’s main components, and other existing maternity and child health services?

- a. To what extent do these relationships align with the pou of Te Tiriti, Equity, Pae Ora, and ways of working?
- b. What are the strengths and barriers of NSPP and SRS relationships, and how might we improve inter-sectoral collaboration and alignment?

The KEQs, along with outcomes, indicators, and data sources, are detailed in the Evaluation Framework (Appendix 1).

Evaluation rubrics

Alongside the evaluation framework, our team co-designed the following evaluation rubrics with the Ministry. The rubrics contain performance criteria and indicators, in identifying the effectiveness of the NSPP, and where and how it can be improved. During the evaluation, we ‘searched’ for the presence or absence of these indicators, the data from which produced our overall evaluative insights. Each rubric is presented below, and reproduced in truncated form for each respective KEQ in ‘Key Findings’.

In this report, we use the following metric-based terminology for our evaluative discussions. These are defined as:

- ‘Most’; ‘many’; ‘a number’; ‘numerous’; ‘the majority’: More than 80% of respondents
 - For example, ‘most respondents noted that...’
- ‘Some’: Less than 50% of respondents
- ‘Few’: Less than 20% of respondents

⁸ This KEQ originally used the phrase ‘...‘āiga Pasifika’, but was later changed to ‘whānau Pasifika’. This was to acknowledge the numerous Pacific peoples and their languages in Aotearoa today, and that ‘āiga’ is not the exclusive Pacific word for ‘family’. For consistency, we thus opted to use ‘whānau Pasifika’ instead.

KEQ1: To what extent does the content, design, and delivery of NSPP and SUDI prevention-related services (SRSs) meet the needs of Māori, Pasifika, and other priority populations?

Measure/Goal: Māori, Pasifika, and other priority populations are receiving (accessing and engaging) NSPP and SUDI related services that meet their needs.

<p>Te Hihiri Energising and enlightening <i>Highly effective</i></p>	<p><u>All of the process indicators</u> listed under Te Tiriti, Equity and Pae Ora are evident within all of the NSPP and SRSs. <u>All elements of the NSPP and SRS service requirements</u> demonstrate an exemplary level of performance that confirm Māori, Pasifika and other priority populations are <u>receiving services and supports that meet their needs</u>. Challenges related to content, design and delivery <u>are not significant and managed effectively and efficiently</u>.</p>
<p>Te Pupuke Expanding influence <i>Consolidating effectiveness</i></p>	<p><u>A clear majority of the process indicators</u> listed under Te Tiriti, Equity and Pae Ora are evident within of the NSPP and SRSs. <u>A clear majority of the NSPP and SRS service requirements</u> demonstrate a <u>sound level of performance</u> that confirm Māori, Pasifika and other priority populations are receiving services and supports that meet their needs. Challenges related to content, design and identified and addressed in a timely manner.</p>
<p>Te Kukune Extending with confidence <i>Developing effectiveness</i></p>	<p><u>Most of the process indicators</u> listed under Te Tiriti, Equity and Pae Ora are evident within all the NSPP and SRSs. <u>Most of the elements of the NSPP and SRS service requirements</u> demonstrate a <u>commendable level of performance</u> that confirms Māori, Pasifika and other priority populations are receiving services and supports that meet their needs. Challenges related to content, design and delivery are identified, but not fully addressed.</p>
<p>Te Whaingā The pursuit of dreams <i>Minimally effective</i></p>	<p><u>Some⁹ of the process indicators</u> listed under Te Tiriti, Equity and Pae Ora are evident within all of the NSPP and SRSs. <u>Some of the NSPP and SRS service requirements</u> demonstrate an <u>average level of performance</u> that confirms Māori, Pasifika and other priority populations are receiving services and supports that meet their needs. Challenges related to content, design and delivery can impact workflows/deliverables.</p>
<p>Te Rapunga Seeking and growing <i>Ineffective</i></p>	<p><u>Very few of the process indicators</u> listed under Te Tiriti, Equity and Pae Ora are evident within all of the NSPP and SRSs. <u>Very few of the NSPP and SRS service requirements</u> demonstrate the <u>minimum level of performance</u> that confirms Māori, Pasifika and other priority populations are receiving services and supports that meet their needs. This does not meet minimum expectations/requirements, and Māori, Pasifika and other priority populations are not provided adequate service.</p>
<p>Te Kore The void of latent potential <i>Insufficient evidence</i></p>	<p>Project documentation reviewed, and qualitative interviews conducted, present limited evidence for any of the process indicators listed under Te Tiriti, Equity and Pae Ora. Data sources are incomplete or conflicted. Evidence is unavailable or of insufficient quality to determine performance. There is potential, but it has not yet been harnessed.</p>

⁹ That is, less than half.

KEQ1a: In what ways are whānau Māori and ‘āiga Pasifika supported to access, engage, and utilise NSPP services and SRSs?

Measure/Goal: Māori, Pasifika, and other priority populations are receiving (accessing and engaging) NSPP services and SUDI related services that meet their needs.

<p>Te Hihiri Energising and enlightening <i>Highly effective</i></p>	<p>NSPP services and SRSs provide services in a way that demonstrate <u>exemplary performance in following elements:</u></p> <ul style="list-style-type: none"> ● Are culturally safe ● Are whānau-centred and strengths-based ● Builds whānau capability and he māia (the courage to parent as Māori) ● Enable access and support ongoing engagement of Māori, Pasifika, and priority populations with the programme ● Supports the uptake and reach to Māori and Pasifika whānau ● Promotes clear, credible and consistent messaging ● Relevant to Māori and Pasifika contexts and experiences ● Relate and connect to Māori and Pasifika experiences ● Are informed and shaped by relatable narratives around Māori and Pasifika child and maternal health ● Identify multiple pathways (options) and links to related child and maternal health services (e.g. Stop smoking services.) ● Resonates with how Māori and Pasifika whānau want to be engaged (co-design etc.)
<p>Te Pupuke Expanding influence <i>Consolidating effectiveness</i></p>	<p>NSPP services and SRSs provide services in a way that demonstrate <u>ALL of the elements under Te Kukune, and demonstrate strong performance in MOST of the following:</u></p> <ul style="list-style-type: none"> ● Are informed and shaped by relatable narratives around Māori and Pasifika child and maternal health ● Identify multiple pathways (options) and links to related child and maternal health services (e.g Stop smoking services, etc.) ● Resonates with how Māori and Pasifika whānau want to be engaged (co-design etc.) ● Supports the uptake and reach to Māori and Pasifika whānau ● Promotes clear, credible and consistent messaging ● Relevant to Māori and Pasifika contexts and experiences ● Relate and connect to Māori and Pasifika experiences
<p>Te Kukune Extending with confidence <i>Developing effectiveness</i></p>	<p>NSPP services and SRSs provide services in a way that demonstrate <u>ALL of the following elements under Te Whaingā and demonstrate improvements in SOME of the following:</u></p> <ul style="list-style-type: none"> ● The promotion of clear, credible and consistent messaging ● Are relevant to Māori and Pasifika contexts and experiences ● Relate and connect to Māori and Pasifika experiences
<p>Te Whaingā The pursuit of dreams <i>Minimally effective</i></p>	<p>NSPP services and SRSs provide services in a way that demonstrate all <u>the following elements:</u></p> <ul style="list-style-type: none"> ● Are culturally safe ● Are whānau-centred and strengths-based ● Are relevant to Māori and Pasifika contexts and experiences ● Enable access and support ongoing engagement of Māori, Pasifika, and priority populations with the programme

<p>Te Rapunga Seeking and growing <i>Ineffective</i></p>	<p>NSPP services and SRSs provide services in a way that demonstrate at least three of the elements under Te Whaingā are present. Despite evidence of these elements, there is clear room for improvement.</p>
<p>Te Kore The void of latent potential <i>Insufficient evidence</i></p>	<p>Project documentation reviewed, and qualitative interviews conducted, present limited evidence for any of the process indicators for Māori, Pasifika, and other priority populations receiving (accessing and engaging) SUDI related services that meet their needs. Data sources are incomplete or conflicted. Evidence is unavailable or of insufficient quality to determine performance. There is potential, but it has not yet been harnessed.</p>

KEQ 1b: What is working well, for whom and in what ways? What can be improved?

Concept: *This formative-focussed evaluation question is supplementary to the process-based KEQ1 and KEQ1a. We seek to identify ways of improving and refining the NSPP and SRS service requirements, by identifying key insights and learning opportunities to strengthen the relevance, impact, and implementation of the programme. The indicators below are included to demonstrate the additional aspects we are assessing as part of our evaluation. We expect that other aspects will surface as we undertake the evaluation.*

Measure/Goal: Māori, Pasifika, and other priority populations are receiving (accessing and engaging) NSPP and SUDI related services that meet their needs.

- Programme messaging is presented in a range of ways to meet the diverse needs of mothers and whānau
- Programme documentation is accurate and regularly updated
- Programme initiatives, outputs and outcomes are being delivered as intended and to budget (Efficiency-effectiveness)
- Equity focus is evident across the resources and investments of the programme
- Programme initiatives are impacting positively on key groups (Relevance)
- Programme initiatives are influencing and strengthening collaboration (Supporting access and engagement)
- Referral pathways and opportunities identified
- Service enablers identified and incorporated in programme design
- Obstacles to service delivery identified, with opportunities for mitigation
- Continuous quality improvement cycles are evident

KEQ2: What is the quality of the relationships between the main components of the NSPP, and other existing maternity and child health services?

Measure/Goal: Main components of the NSPP are cohesively working and collaborating with other existing maternity and child health services to better deliver NSPP and SRS service requirements.

<p>Te Hihiri Energising and enlightening <i>Highly effective</i></p>	<p>Kaupapa partner relationships with other existing maternity and child health services demonstrate <u>exemplary performance in ALL of the following elements:</u></p> <ul style="list-style-type: none"> ● Partnership-based between whānau Māori and providers ● Strengths-based and positive ● Built on a shared understanding of each others' role and responsibilities ● Able to evidence effective working relationships across all levels of their programme ● Supported and activated by the appropriate leader, and at the appropriate level ● Agile, informed, and able to be mobilised effectively ● Designed and delivered to benefit whānau and configured to meet their needs ● Seamlessly connecting with the community and with other services ● Enhanced by cohesive communication and actions ● Resourced appropriately and valued as a strength of the programme
<p>Te Pupuke Expanding influence <i>Consolidating effectiveness</i></p>	<p>Kaupapa partner relationships with other existing maternity and child health services demonstrate <u>ALL of the elements under Te Kukune, and demonstrate strong performance in MOST of the following:</u></p> <ul style="list-style-type: none"> ● Supported and activated by the appropriate leader, and at the appropriate level ● Agile, informed, and able to be mobilised effectively ● Designed and delivered to benefit whānau and configured to meet their needs ● Seamlessly connecting with the community and with other services ● Enhanced by cohesive communication and actions
<p>Te Kukune Extending with confidence <i>Developing effectiveness</i></p>	<p>Kaupapa partner relationships with other existing maternity and child health services demonstrate <u>ALL of the following elements under Te Whaingā and demonstrate improvements in SOME of the following:</u></p> <ul style="list-style-type: none"> ● Seamlessly connecting with the community and with other services ● Enhanced by cohesive communication and actions ● Resourced appropriately and valued as a strength of the programme
<p>Te Whaingā The pursuit of dreams <i>Minimally effective</i></p>	<p>Kaupapa partner relationships with other existing maternity and child health services demonstrate <u>all the following elements:</u></p> <ul style="list-style-type: none"> ● Partnership-based between whānau Māori and providers ● Built on a shared understanding of each others' role and responsibilities ● Designed and delivered to benefit whānau and configured to meet their needs
<p>Te Rapunga Seeking and growing <i>Ineffective</i></p>	<p>Kaupapa partner relationships with other existing maternity and child health services demonstrate at least two of the elements under Te Whaingā. Despite evidence of these elements, there is clear room for improvement.</p>
<p>Te Kore The void of latent potential</p>	<p>Project documentation reviewed, and qualitative interviews conducted, present limited evidence for any of the process indicators for/that kaupapa partners are cohesively working and collaborating with other existing maternity and child</p>

<i>Insufficient evidence</i>	health services to better deliver NSPP services and SRSs. Data sources are incomplete or conflicted. Evidence is unavailable or of insufficient quality to determine performance. There is potential, but it has not yet been harnessed.
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KEQ2a: To what extent do these relationships align with the pou of Te Tiriti, Equity, Pae Ora, and ways of working?

Measure/Goal: The main components of the NSPP are cohesively working and collaborating with other existing maternity and child health services to better deliver NSPP and SRS service requirements.

<p>Te Hihiri Energising and enlightening <i>Highly effective</i></p>	<p><u>All of the process indicators</u> listed under Te Tiriti, Equity, Pae Ora, and Ways of Working, are evident in the relationships of the NSPP and SRSs. <u>All elements of the relationships demonstrate an exemplary level of performance</u> that confirms they are cohesively working and collaborating with other <u>existing maternity and child health services to better deliver NSPP services and SRSs</u>. Challenges related to content, design and delivery <u>are not significant and managed effectively and efficiently.</u></p>
<p>Te Pupuke Expanding influence <i>Consolidating effectiveness</i></p>	<p><u>A clear majority of the process indicators</u> listed under Te Tiriti, Equity, Pae Ora, and Ways of Working, are evident in the relationships of the NSPP and SRSs. <u>A clear majority of the relationships demonstrate a sound level of performance</u> that confirms they are cohesively working and collaborating with other <u>existing maternity and child health services to better deliver NSPP services and SRSs</u>. Challenges related to content, design and identified and addressed in a timely manner.</p>
<p>Te Kukune Extending with confidence <i>Developing effectiveness</i></p>	<p><u>Most of the process indicators</u> listed under Te Tiriti, Equity, Pae Ora, and Ways of Working, are evident in the relationships of the NSPP and SRSs. <u>Most of the elements of the relationships demonstrate a commendable level of performance</u> that confirms they are cohesively working and collaborating with other <u>existing maternity and child health services to better deliver NSPP services and SRSs</u>. Challenges related to content, design and delivery are identified, but not fully addressed.</p>
<p>Te Whaingā The pursuit of dreams <i>Minimally effective</i></p>	<p><u>Some of the process indicators</u> listed under Te Tiriti, Equity, Pae Ora, and Ways of Working, are evident in the relationships of the NSPP and SRSs. <u>Some of the elements of the relationships demonstrate an average level of performance</u> in working and collaborating with other <u>existing maternity and child health services to better deliver NSPP services and SRSs</u>. Challenges related to content, design and delivery can impact workflows/deliverables.</p>
<p>Te Rapunga Seeking and growing <i>Ineffective</i></p>	<p><u>Very few of the process indicators</u> listed under Te Tiriti, Equity, Pae Ora, and Ways of Working, are evident in the relationships of the NSPP and SRSs. <u>Very few of the elements of the relationships demonstrate the minimum level of performance</u> in working and collaborating with other <u>existing maternity and child health services to better deliver NSPP services and SRSs</u>. This does not meet minimum expectations/requirements.</p>

<p>Te Kore The void of latent potential</p> <p><i>Insufficient evidence</i></p>	<p>Project documentation reviewed, and qualitative interviews conducted, present limited evidence for any of the process indicators under Te Tiriti, Equity, Pae Ora, and Ways of Working. Data sources are incomplete or conflicted. Evidence is unavailable or of insufficient quality to determine performance. There is potential, but it has not yet been harnessed.</p>
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KEQ 2b: What are the strengths and barriers of NSPP and SRS relationships, and how might we improve inter-sectoral collaboration and alignment?

Concept: *This formative-focussed evaluation question is supplementary to the process-based KEQ1 and KEQ1a. We seek to identify the strengths and barriers of the NSPP and SRS relationships, and inter-sectoral collaboration and alignment. The indicators below are included to demonstrate the additional aspects we are assessing as part of our evaluation. We expect that other aspects will surface as we undertake the evaluation.*

Measure/Goal: The main components of the NSPP are cohesively working and collaborating with other existing maternity and child health services to better deliver NSPP services and SRSs

- Strengths and barriers of relationships are identified, analysed and addressed
- Relationships are positively influencing and supporting inter-sectoral collaboration
- Relationships and partnership approaches are evident across most service delivery
- Relationships with key groups are woven into all aspects of their workplans/streams
- Relationships have a shared understanding of key strategic documents and commit to activating these in their ways of working

This report

This evaluation report responds to the above KEQs, with the rubrics employed to provide evaluative conclusions on the effectiveness of the kaupapa, and where and how it can be improved.

Limitations

Limitations of *Kia Puawai* are outlined below:

- During data collection, most kōrero tended to gravitate towards KEQ1b. Most participants saw deficiencies with the current design of the NSPP, and offered suggestions on improving this to better address inequitable SUDI rates among Māori, Pasifika, and other priority populations. As such, data for KEQ 2a is limited, and as the scope of the evaluation was to explore how the NSPP could be improved, we have left this unanswered. This is because a design refresh, discussed at length throughout the key findings, is geared towards providing a sustainable basis for alignment of relationships with Ngā Pou. Further, KEQ2b presumes a level of coherency in the current NSPP design, and as it is also focussed upon improvements, this has been subsumed into KEQ 1b.
- We exclusively spoke with service providers, rather than service users. Conducting interviews with users (such as whānau and māmā) would also have

required ethics consent and approval, which was not pursued in *Kia Puawai* because of the evaluation's service-delivery focus. The number of interviews completed, and the consistency of themes from participants across the NSPP and SRSs, strengthen the findings presented in this report. The achieved sample size has enabled the diversity of perspectives to be heard, but, again, these are voices from service providers, not users.

- Kaupapa Māori evaluation holds space for a participatory process that builds connections and trust between respective services, and their intended audiences. We acknowledge some voices were not heard, and continue to hold space for their experiences and insights, should they surface in other work currently underway. Time limitations meant incorporating other voices required more detailed focus than we could provide.

Key findings

This section details the key findings of the evaluation under the six KEQs. Each KEQ presents a high-level summary, detailed discussion, and rubric analysis.

KEQ 1: To what extent does the content, design, and delivery of NSPP and SUDI prevention-related services (SRSs) meet the needs of Māori, Pasifika, and other priority populations?

KEQ1 explored the extent to which the content, design and delivery of NSPP and SUDI prevention-related services meets the needs of Māori, Pasifika, and other priority populations. Based on data collected, we have determined that current progress, as read through the rubric for this KEQ, sits between Te Whāinga (minimally effective) and Te Kukune (developing effectiveness).



Our rating is based on the following assessment of the process indicators detailed in the rubric. Those indicators advance that in order to meet the needs of Māori, Pasifika, and other priority populations, the NSPP and SRSs would provide services in particular ways. Each of these are detailed below, with discussion and findings provided thereafter. Thus, the NSPP and SRSs should provide services in a way that:

- **Are based on, and delivered within, mātauranga Māori and tikanga Māori, and particularly on kaupapa Māori concepts of tamariki Māori health and wellbeing within the context of whānau**

There is clear evidence that mātauranga Māori and tikanga Māori principles are a part of the core service components for the NSPP and SRSs. The majority of participants spoke consistently on the importance of whānau approaches in creating lasting change, in the pursuit of meaningful outcomes for whānau. In some cases, services provided were distinctly kaupapa Māori, or Māori-led. This, for example, included delivering, or supporting the development of, wānanga wahakura, and bringing in local weavers to do so. There was also a marked attempt to reduce barriers of access for māmā to these wānanga, which might mean “picking whānau up [and] feeding them”. This also means ensuring service delivery to whānau is culturally appropriate,

which is why Safe Sleep Coordinators in general require or encourage distributors of wahakura to undertake cultural competency training, and/or undertake the NSPCS's Online Training modules.

'Risk' and deficit thinking

One point of contention, in terms of mātauranga Māori and kaupapa Māori, concerned the focus on 'risk'. Previous iterations of SUDI (or SIDS) intervention have concentrated on 'at-risk' whānau and māma, but many voiced concerns that continuing this approach is deficit- rather than strengths-based (the former being inconsistent with kaupapa Māori principles). For example, there was conflict in the EAG concerning the distribution of ISSBs, with some believing ISSBs should be targeted only to at-risk whānau. Given this, there was some emphasis placed on the development of a 'risk calculator', to determine where SUDI prevention is best targeted. By contrast, numerous participants (particularly in kaupapa Māori or Pacific providers) felt that such an approach is deficit-based, requiring Māori and Pasifika to already be 'failing' in order to receive support. Indeed, others on the EAG advocated that all māma, regardless of their situation, should be offered ISSBs (particularly wahakura). This perspective is echoed by one DHB participant:

"I just want to give all our Māori māma [wahakura]. Why not? ... It's about... normalising these practices in the home without having to have a risk factor. Why do we have to have a risk factor? Why can it [not] be an empowering positive tikanga Māori kaupapa, because this is what we do? And instead it's negatively framed around, 'You have to smoke, your baby has to be premature and low birth weight'. You know it's more around what you're doing wrong, as opposed to, 'Whānau, ...these are your taonga. Let's give them to you because this is our Māori practice.'"

- **Partner with Māori leadership and stewardship**

Most participants interviewed were able to provide an account of how Māori leadership and stewardship was activated in their respective service. This ranged from knowing the name of the service providers delivering NSPP and SRS-related kaupapa in their region, to having advisory groups and Māori health teams, who were tasked with providing the Maori leadership and stewardship in the service, to directly partnering with Māori health leadership in the sector. On balance, the capacity to activate this process indicator varied with participants interviewed, and there is room to strengthen this in developing a more cohesive approach to demonstrate partnership with Māori leadership.

- **Supports tino rangatiratanga and mana motuhake within child and maternal health**

Participants at an advisory and governance level role identified that the principles in this process indicator are critical to providing a service that meets the needs of Māori and Pasifika. However, at the operational level of service delivery, participants had varying levels of confidence to speak to these principles in practice. Those comfortable and familiar with Te Ao Māori approaches reported similar sentiments as the advisory and governance level participants.

The importance of Māori and Pasifika leadership and approaches

These last three indicators are reflected in participants' emphasis on 'taking the lead' from Māori and Pasifika leadership. In some DHBs, we saw support for 'by Māori and Pacific, for Māori and Pacific' approaches to SUDI prevention. The main justification for this, as respondents from DHBs, Safe Sleep Coordinators, and related services reiterated, is that Māori and Pacific peoples disproportionately experience SUDI. As one provider emphasised, "[our service] attempts to reflect the demographic most impacted by SUDI – Māori communities." For another Safe Sleep Coordinator, this meant "ensuring Māori have a voice" in the design and delivery of SUDI prevention services.

In practice, this has looked like being guided by Māori and Pasifika health leadership. In one example, a DHB explicitly recognised that Te Tiriti obligations meant allowing Māori/iwi health providers to set the direction across all aspects of health, including SUDI prevention. As other DHB respondents emphasised in relation to this,

"What Te Arawa Whanau Ora provide here is quite different to Tūwharetoa."

"You know what works in Te Taitokerau doesn't work in Tāmaki necessarily."

Here, the DHB in question sought advice from iwi and Māori organisations in the region on how services could be better provided, through a co-design process. Advice was provided in this capacity, suggesting the DHB should have multiyear contracting, rather than year-to-year contracts for Māori health. To this end, the DHB adopted a three- to five-year funding agreement, which was implemented earlier this year. This approach was galvanised by the DHB's broader processes of establishing Māori leadership groups in other areas of health, such as cardiovascular disease. Other DHB representatives shared similar sentiments – that short term contracts are not ideal – and security of funding over longer periods is needed, to effect more robust, equitable interventions in SUDI prevention. As one portfolio manager described,

“[T]here’s no stability [in short term contracts]... We’ll pass as much through as we can, but it’s really hard when it’s not for five years [for example].”

These examples emphasise the need to work with Māori and Pasifika communities in SUDI prevention, especially given SUDI rates are disproportionately experienced by them. Further, while these examples exemplify what ‘good’ can look like, such approaches were not adopted across the board, which is why we have stressed that ‘change can be had.’

- **Are flexible, whānau-centred, and build whānau capacity**

Across numerous DHBs, Safe Sleep Coordinators, and Regional Coordinators, there was a strong commitment to providing a ‘whānau-centred’ approach, or working towards this type of model. (This was captured across conversations around engagement and recruitment with whānau, in offering SUDI prevention-related services). However, this was frustrated in practice by the current design of the NSPP. Throughout, there was a desire and effort to work towards this intent, but the consistent challenge was misalignment or lack of cohesive integration with other services in the WCTO ecosystem. This has made it difficult to provide a comprehensive service that is flexible and genuinely whānau-centred. As some respondents highlighted, the strength of a kaupapa such as SUDI prevention should lie in its ability to provide māmā with a suite of maternity and general health services. Further, timing and engagement with those at risk of SUDI was a consistent challenge or limitation in the service design.

- **Actively demonstrate their commitment to achieving equitable outcomes for Māori**
- **Demonstrates they understand the importance of outcomes and the direction and distribution of efforts required to achieve equity for Māori, Pasifika, and other priority populations**
- **Resources kaupapa Māori services to achieve equity across all levels of the programme**

Service level roles demonstrated an understanding of the effort and action required to achieve equity for Māori, but at present, the design of the programme does not effectively target this.¹⁰ This is primarily due to the fragmented nature of investment, with different components of the programme receiving funding siloed from other services (this is detailed at length in KEQ1b, with a potential future model detailed on

¹⁰ This echoes the finding of Litmus’ 2020 *Key insights from whānau Māori research and literature to inform the WCTO programme review*, which emphasised the increasing inequity of access and outcome for whānau Māori (see p. 3; see also Litmus 2020, *The literature review report on the design features to improve equity for Māori in the WCTO programme*).

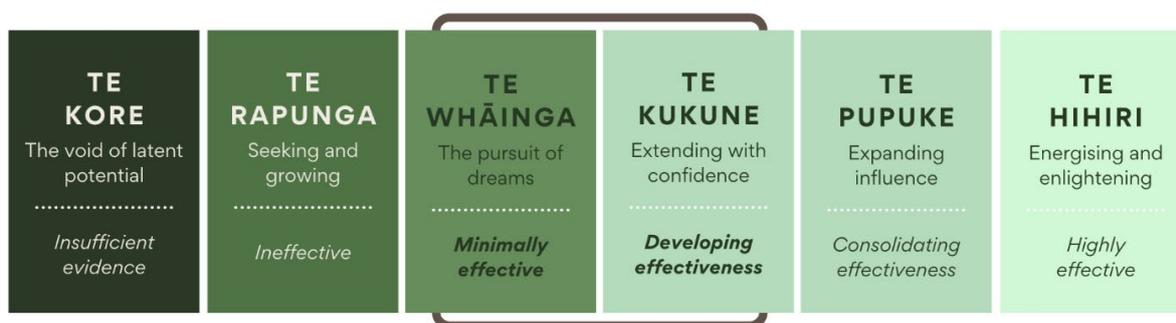
pp. 36-7). Further, some participants were conscious of their limitations in activating this indicator, but reported that their service level response was improving given the confines of the programme at present. Other limitations that exacerbate provision of equitable health outcomes and resourcing, from a service design perspective, include a lack of Māori and Pasifika staffing, and many emphasised the need to ensure the workforce is equipped to deliver services in ways that resonate with Māori, Pasifika and other priority populations. This gap is especially obvious in support for Pasifika, which, overall, appeared to be lacking. Investment into kaupapa Māori services remains a point of tension, in terms of achieving equitable outcomes.

- **Are designed and informed by Māori with lived experience and insights with SUDI**

There was insufficient data collected to measure this process indicator, as most participants could not speak to this point. Whilst there were some artefacts reviewed and actions reported towards this, we are unable to make an agreed assessment of how well this process indicator is being activated across the roles in the content, design and delivery of NSPP and SUDI prevention-related services.

KEQ 1a: In what ways are whānau Māori and whānau Pasifika supported to access, engage, and utilise NSPP services and SRSs?

KEQ1a examined the ways whānau Māori and whānau Pasifika are supported to access, engage, and utilise NSPP services and SRSs. Based on data collected, we have determined that current progress, as read through the rubric for this KEQ, sits between Te Whaingā (minimally effective) and Te Kukune (developing effectiveness).



Our rating is based on the following assessment of the process indicators detailed in the rubric. Those indicators advance that in order to meet the needs of Māori, Pasifika, and other priority populations, the NSPP and SRSs would provide services in particular ways. Each of these are detailed below, with discussion and findings provided thereafter (some of which is repeated from KEQ1). Thus, the NSPP and SRSs should provide services in a way that:

- **Are culturally safe**

As KEQ1 identified, mātauranga Māori and tikanga Māori principles are part of the core service components for the NSPP and SRSs. Some services are delivered in culturally relevant appropriate ways, but it is unclear if the experience of them by māmā and whānau is culturally safe across the breadth of the NSPP. For example, where possible, whānau weave their own wahakura, and safe sleep messaging can be (and is) delivered through the wānanga itself. Here, different strands of harakeke might represent the role of different whānau members in baby's care and nurturing for safe sleep; and in the action of weaving, messaging is repeated by those present (such as 'Baby sleeps on their back'). This echoes a point emphasised throughout the evaluation: ISSBs such as wahakura are not the 'answer' in and of themselves, but rather the suite of messaging and good practice that accompanies them.

Further, messaging and related material is often translated into different languages, such as te reo and other Pacific languages. However, as one Safe Sleep Coordinator noted, there is a need for more Pacific language material to be developed and distributed. While the foundations of culturally safe practice are certainly present, especially through taking the lead from Māori and Pacific health leadership, we were unable to determine how culturally safe the provision of services are, as our team did

not speak directly with māmā or whānau to make a conclusive assessment. This is exacerbated by the fragmented nature of SUDI prevention investment across the programme's key components, and KEQ1b details a design refresh aimed to more directly address this and other concerns raised (see pp. 36-7).

- **Are whānau-centred and strengths-based**

As identified in KEQ1, while there is a strong commitment to providing a 'whānau-centred' approach, the current configurations of the NSPP make it challenging to provide a flexible and genuinely whānau-centred service.

- **Builds whānau capability and he māia (the courage to parent as Māori)**
- **Enable access and support ongoing engagement of Māori, Pasifika, and priority populations with the programme**
- **Supports the uptake and reach to Māori and Pasifika whānau**

Because data collected was at a service delivery level, we are only able to report their perspectives of how capability and 'he māia' is being activated through the NSPP and SRS related services. This is likewise the case with providing assessment on the ability to access and support ongoing engagement, including uptake and reach of Māori and Pasifika.

Kaimahi underscored that supporting whānau capability, to access and utilise the suite of services available to them, involves identifying the needs of whānau, and elevating the values that resonate with them in the delivery of those services. Moreover, service design and delivery approaches that understand what these values are, in practice, are more likely to support services that integrate information. These include referral pathways for related services, and strong advocacy approaches that include options and strengths based solutions. This is also the case for promoting local collaborative models that uplift whānau capability and capacity, to reduce SUDI risk factors for their whānau.

Across the board, participants reported that the uptake and reach components of their mahi continue to be impacted by a disjointed inter-sectoral approach. The current design has no agreed framework or pathway to ensure Māori and Pasifika whānau access and remain engaged with the services. Enhancing the quality of the NSPP and SRSs at a system level thus continues to challenge and hinder service design limitations for Māori and Pasifika whānau. This has been a consistent and enduring challenge for these services since the inception of the NSPP.

- **Promotes clear, credible and consistent messaging**

There was consistent feedback from participants that there is a lack of clear and consistent messaging, resulting from the absence of a coordinated and centralised advisory body to provide information on messaging. This is detailed further in KEQ1b, but for now, messaging is largely ad hoc and unclear, with some commenting that it is unclear if baseline safe sleep messages resonate with Māori and Pasifika. As one participant commented,

“We’ve always used the ‘PEPE’ message... and I don’t know how well that resonates with our Māori and Pasifika whānau to be honest.”

To be clear, this participant was emphasising that the acronym itself may not be well received by whānau, and therefore, ineffective at promoting safe sleep messages (a more relevant acronym, for example, might be ‘MOE’). This more broadly reflects the need to ensure messaging is user-tested with māmā and whānau before it is disseminated. Clear messaging is pivotal in translating medical knowledge and advice into practice, which is why we have below suggested (in KEQ1b) that culturally-grounded science communication skills be included in the advisory body.

- **Relevant to Māori and Pasifika contexts and experiences**
- **Relate and connect to Māori and Pasifika experiences**
- **Are informed and shaped by relatable narratives around Māori and Pasifika child and maternal health**
- **Resonates with how Māori and Pasifika whānau want to be engaged (co-design etc.)**

Building in Māori and Pasifika contexts and experiences, as key levers to support the reach and uptake of NSPP and SRSs, varies across service providers. As we have described, some are anchored in robust kaupapa Māori approaches, whilst others defer to their contracted partnerships with Māori services. This is the sum of how these aspects are woven into their delivery. Many participants highlighted the need to have a key role that targets Māori and Pasifika whānau to access and remain engaged with their services. This is premised, however, upon the presence of a suitably qualified workforce, with an appropriate level of cultural capacity and capability to deliver in ways that resonate with Māori and Pasifika whānau. We could not establish this based on the data collected through interviews and documentation.

We acknowledge there are confounding variables and circumstances in this kaupapa, due to the complex and sensitive nature of SUDI. However, the need to explore experiences and narratives, in identifying ways to strengthen service delivery relevancy and partnership approaches with whānau, remains unmet. Further, the lack of data around the content and design elements of existing service configurations

continues to exacerbate the ability to measure and track the journey towards meeting the child and maternal health needs of Māori and Pasifika whānau. *Kia Puawai* asserts that these gaps, in quality service design, are combative to the equity principle embedded in Ngā Pou, and the evolving health management approaches currently being pursued in Māori health more generally.

- **Identify multiple pathways (options) and links to related child and maternal health services (e.g., smoking, etc.)**

There was some evidence of wraparound services being provided to whānau in the home, as well as connecting them to other child and maternal health services they might not be aware of. This was to broaden the focus from māmā to everyone in the whānau, “...so everyone understand[s] the risks around [babies].” As one Safe Sleep Coordinator described,

“We’d look at going into the home and actually talking to everybody, offering some of those supportive services [and] how they can get to them. [Sometimes that means] taking them into the appointment [or] linking them into those supportive services to improve the wider whānau health.”

This approach was adopted in other regions as well, where SUDI prevention services were provided in concert with other maternity health services, such as hapū and rongoā wānanga, smoke free services, and so forth. However, as identified earlier, this is not universally the case, stemming from the disjointed nature of the programme as it currently stands.

KEQ1b: What is working well, for whom and in what ways? What can be improved?

KEQ1b probed respondents' views on what is working well, what is not, and where things can be improved. As this was an in-depth exploration of how the NSPP can, in essence, be strengthened overall, there is no rubric analysis or assessment for this KEQ. Much of our kōrero with respondents tended to gravitate towards these foci, and is detailed below. A potential future model is detailed thereafter, summarising much of what is discussed here. Further, as explained, discussion relevant to KEQ2b has been subsumed into this section.

What's working well?

For many participants, wahakura are the preferred ISSB for distribution. As one participant commented, “we actually bought in more of the resource [i.e., wahakura] that whānau were telling us were more appropriate for them.” Most participants felt wahakura are more culturally appropriate and relevant to Aotearoa's context, with the physical act and metaphor of weaving a powerful one for SUDI prevention. In this way, knowledge and key messaging is interwoven into the wahakura, and provided to whānau and māmā either through wānanga wahakura, or in the delivery of completed wahakura. From collective Māori perspectives on this, wahakura are “a taonga versus a commodity”, and are more environmentally friendly as they use sustainable materials and ‘do better for Papa-tūā-nuku’. As one participant noted,

“No matter where you drive in Aotearoa, there is harakeke everywhere. That tells me there are plenty of resources – it's not just a resource, it's a rongoā. It belongs to Papa-tūā-nuku; it's whanau the whole way, [with] roots grow[ing] [and] bursting new shoots.”

This emphasises the metaphor of birth and nurturing young, as well as the sustainability and cultural relevance of harakeke and raranga to new life. As another respondent mentioned,

“You know the strength of the cultural connection [of wahakura] is just absolutely vital, but also if we're talking about sustainability, environmental impact, and for Papa-tūā-nuku, then... wahakura is the thing.”

There has been a discernible increase in demand for wahakura production and distribution, and the NSPCS have been supporting the establishment of wānanga wahakura across the country. One provider in Mid Central brings together health professionals or midwives into the wānanga, who can provide expertise on key safe sleep messaging during the wānanga. One EAG member cautioned that this needed to

happen in all wānanga, to ensure best practice is communicated clearly at the interface between providers and whānau/māmā. Resourcing wānanga wahakura (or related wānanga) is limited however, as one Safe Sleep Coordinator identified:

“[O]ur hapū [and wahakura] wananga... are really awesome here and growing; what we need is more [and the] ability to do those more often.”

One DHB respondent, however, noted that in their area, many whānau still prefer pēpi-pod®. This was an outlier in our findings, and the same respondent also noted that uptake of wahakura had increased in recent years.

What’s not working well?

In sum, the NSPP has an outputs-focus, and can be characterised as a macro-level programme that delivers a micro-level intervention. This is frustrated by systemic issues around social determinants of health (housing, financial stability, and so forth), as well as a disjointed, incohesive design that lacks a centralised, coordinated approach.

Outputs rather than outcomes

In general, participants reported that the programme, as it stands now, is more focussed on outputs (delivery of services) rather than outcomes (identifiable shifts in behaviour contributing to lowering SUDI instances). At the programme delivery level of the service, there is currently no built-in evaluation of how effective services are in contributing towards overall programme outcomes. For example, DHB reporting is largely output-focussed (i.e., the quantum of ISSBs distributed).

As emphasised at length by the majority of those we spoke with, ISSBs are not a ‘silver bullet’ to addressing inequity in SUDI rates, but are only a part of the broader solution. Key messaging and best practice must accompany the delivery or manufacture of wahakura, pēpi-pod®, or other ISSBs, and the key focus should be on providing quality engagement to this end. For some Regional Coordinators, this is exacerbated by having “narrow outcome-focussed requirements” in Crown Funding Agreements (CFA), suggesting a need to change the CFAs to be more outcomes- than outputs-focussed. Similarly, some DHBs, in practice, see wahakura more as a commodity – an output – rather than as a component in a broader suite of messaging and services to ensure baby ‘sleeps safe’ all the time.

Lack of integration, and fragmentation of investment

Throughout, participants noted the disjointed nature of the programme, stemming from its siloed nature from other aspects of the maternity health landscape, such as the WCTO, General Practice, Public Health and Smoking Cessation services. This is largely due to the way the NSPP was developed, which did not fully replicate the

approach adopted by earlier iterations (such as SIDS). At the moment, as one participant noted, “It feels like SUDI is tacked on [rather than a core component]”. As another described,

“[C]ontracts... sit in spaces where you end up with management [at] different levels... actually it needs to be sitting within community spaces, where you have the ability to have a range of kaimahi who connect in the role [in a cohesive manner].”

Similarly, because of this lack of integration, the SUDI prevention investment is fragmented across these services. There is no overall ‘map’ to coordinate the delivery and integration of services, with services nested away from one another. Because of this, there is likewise no whole-of-programme systems leadership or leadership infrastructure, exacerbated by a confusion around ‘who does what’. This characteristic is not unique to SUDI prevention, as the Department of Prime Minister and Cabinet has recently noted:¹¹

“[The health system] is a complex and unnecessarily fragmented [one], with unclear roles, responsibilities and boundaries. This can lead to the organisations operating within the system pulling in different directions, and without a long term view of where they are heading.”

Together, these issues hamper the effectiveness of the programme as a whole. This is why, as we detail below, there is a need for stronger cohesion and integration of SUDI prevention across the maternity and health system in general.

DHB priorities

It was also noted by a number of participants that power and decision making is concentrated at the DHB level. If SUDI prevention is not considered a priority within DHBs, then this will inevitably impact upon service delivery at a local level. While in the same breath many emphasised that the new Māori Health Authority may shift this situation, this remains an enduring reality. This is not to say DHBs do not prioritise SUDI – for many do in unique and innovative ways – but the lack of DHB accountability means this is a barrier to effective, nationwide SUDI prevention service delivery.

Lead Maternity Carer responsibilities

A few participants noted that relationships between Lead Maternity Carers (LMCs/Midwives) and DHBs can be challenging, as at present there is little

¹¹ DPMC, 2021a, p. 2.

accountability of the former to the latter. Further, there is difficulty in getting buy-in from some LMCs/midwives into SUDI prevention, as well as encouraging them to undertake education modules and professional development related to SUDI prevention. This, however, is not a generalisable finding, as some LMCs/midwives do take this into account. Nevertheless, as one DHB participant commented,

“...around 80% of our midwives are our LMCs [who] are self-employed midwives and they’re not really accountable to the DHB... [W]ith our DHB midwives, we can make it mandatory to do specific training and education [like] cultural awareness... but yeah for the majority of our midwives, we can only promote that.”

LMCs are a critical element of SUDI prevention, and they need to be better integrated into the NSPP.

Social determinants of health

Almost all those we spoke with emphasised the need to examine the constitutive role of social determinants to health and SUDI rates. While some felt this was irrelevant and out of scope, as ‘it’s out of our influence’ (there was disagreement on this point in the EAG), almost all others reiterated that issues like financial security and income, inadequate housing or overcrowding, and access to transport, are either stressors or material risk factors for SUDI.

“I think once again what’s not working well is just a siloed view of health.”

In such situations, as one respondent mentioned, giving whānau a wahakura will not ‘make a cold house warm or reduce an overcrowded house’. As was repeated at length, taking a narrow view of SUDI prevention, and seeing it in isolation from these factors, is likely doing the programme a disservice. This suggests the need for a more integrated service delivery of the NSPP with other related government services, such as housing and social welfare. As one EAG member noted, “We shouldn’t just sit by and have SUDI as a tragic marker of [poverty].” As the Waitangi Tribunal have also recently noted in the *Hauora* report,¹²

“While the health system cannot be accountable for all of the social determinants of health, it has available to it some of the strongest levers to effect change.”

¹² Waitangi Tribunal, 2021. *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry, Chapter 10*, p. 21.

What can be improved?

Participants offered a wide variety of suggestions to improve the effectiveness of the NSPP. Many caveated the following with the reminder that the forthcoming Māori Health Authority may modify SUDI prevention delivery, but offered these suggestions nonetheless. These include:

Refresh the design of the programme to better integrate it with other social and health services. A refreshed programme design is needed, which cohesively integrates its services into WCTO, maternity, General Practice, Public Health and Smoking Cessation services. In terms of attracting LMC buy-in, this might include providing accreditable SUDI prevention-related professional development, to tie into midwifery registration. Within DHBs, as one respondent described, the services that target key SUDI risk factors should be intertwined together. She explains:

“I see a bit of an opportunity for us is around those three risk factors, smoking, breastfeeding, and safe sleep. All those three kaupapa need to come together, [in a] cohesive, streamlined way. Currently in the DHB [this is not happening]... [Services like lactation and maternity support are] disconnected from the smoking programme; the smoking programmes disconnected from the breastfeeding programme. And safe sleep’s in the middle trying to work with both and figuring out how we can complement each other. I think we really want an opportunity if we could tighten those programmes and bring them together around māmā, [as] they’re all so connected when it comes to SUDI deaths.”

In this way, better integration is needed to link the NSPP in with related services both in health, and other sectors such as housing and education. This, for example, might include agencies such as Kāinga Ora, Oranga Tamariki, the Ministry of Education, the Ministry of Social Development, Te Puni Kōkiri, the Ministry for Pacific Peoples, and so forth. This would provide, as one EAG member suggested, a “cohesive cocoon of safety for the baby [that brings together] social needs... psychological needs, mental health [needs and] nutritional needs”, with wraparound services from antenatal through perinatal phases. As one Regional Coordinator commented, “I’m not sure that just a safe sleep bed and messaging on its own is enough.”

Have a monitoring or oversight leadership group that maintains and ensures oversight of the programme’s inter-sectoral alignment and cohesion. Given the above, many participants (from DHBs to Regional Coordinators) emphasised the need to have a central leadership group that oversees the integration with related services. This would ensure that the purpose of the NSPP, to meaningfully address inequities in SUDI rates, is being met. As one respondent commented,

“...[at the moment there is] no integrated whole, making sure that the system right through [is] being looked at and analysed, and then reported back to say, ‘Is the original intention actually being met?’”

Similarly, some felt that SUDI is treated as a “tacked on service”, and that SUDI delivery itself is often ‘checkbox’ rather than a substantive explanation of key messaging. This is possibly influenced by the current outputs-rather than outcomes-focus of the programme. This concern was echoed by one Safe Sleep Coordinator, who noted,

“I think the concern for me is... the number of people that get referred after they’ve had the pēpi. [This] says to me that potentially those conversations [about safe sleep messaging] have not actually happened while [they were] hapū, and that is really not kei te pai”.

Invest in relationships and building trust with providers, the sector, and whānau. Trust is key to any kaupapa,¹³ and the following contextual information highlights why. The nationalisation of SIDS to the newly-developed NSPP was not immediate, resulting in an 18 month delay of intervention services. When SIDS was disestablished, to give way for the NSPP, funding cessation meant the networks, trust, and relationships developed with providers and communities through SIDS were no longer resourced. This year-and-a-half delay, explained one EAG member, likely led to increased SUDI rates over this period. This meant the trust and relationships that had been built between the SIDS workforce, providers, and whānau, had been interrupted. As he described,

“So it wasn’t just the paid Māori SIDS workers who were lost. It was the networks in the community... suddenly they were all gone. And so they lost trust... [It meant that the new coordination service] had to start again.”

With SIDS-based relationships put on hold for 18 months, a significant amount of work was needed to rebuild these to what they were. In this light, there were repeated calls to ensure there is trust and genuine relationships amongst both service providers, and whānau. Where such trust and relationships are not present, accessing and engaging with whānau and māmā becomes difficult, which is why so many participants reiterated this as a necessary, central element for service delivery.

¹³ See Litmus, 2020, *Key insights from whānau Māori research and literature to inform the WCTO programme review*, p. 4, and also Ministry of Health, 2020, *Well Child Tamariki Ora Review Report*, p. 25.

Similarly, across the board, word of mouth was the most reliable way of contacting and engaging hapū māmā and their whānau. Some regions and coordinators also use social media, but many emphasised the importance of needing to have first built trust with whānau, in order to encourage them to participate in SUDI prevention services. As one Safe Sleep Coordinator emphasised, ‘without trust and relationships, it doesn’t work’. This can, and is, often leveraged through pre-existing relationships kaupapa partners have in the community, from Māori health and social providers, to GPs and community groups.

Be clear on ‘who does what’. In our discussions with participants, many reiterated the need to have more clarity around the roles and responsibilities of the programme’s various components, so that providers and others knew ‘whose lane was whose’. This would also support the development of stronger relationships, as one DHB participant noted:

“I feel like the SUDI programme... would really benefit from that approach, like bringing everyone together, clarifying your brand’s roles and, at the very least, starting to build up a few better relationships within the sector between people, because that’s ... sorely needed.”

Ensure a programme refresh is whānau-centred and integrated into the community. Participants underscored that a redesign needs to be more strongly whānau-centred, and driven by whānau aspirations of health.¹⁴ This includes needing to emphasise the role of the whole whānau – grandparents, pāpā, other children, and so forth – because SUDI prevention is a ‘whole whānau affair’: “The kaupapa must stay whānau-centred”, commented one Regional Coordinator. As one DHB participant similarly noted, SUDI prevention “is part of everyone’s work”, emphasising this both at a whānau and health organisation level. As others emphasised, there is a need to integrate the kaupapa as a whole into the community, through marae, church groups (especially for Pacific whānau), Kōhanga Reo, Kura Kaupapa, Wharekura, and so forth, and having ‘safe sleep champions’ located in each of the places.¹⁵

Increase and devolve funding arrangements. Some respondents suggested increasing and shifting the funding from DHBs directly to providers – particularly Māori providers – themselves to deliver services. This echoes the findings of the Ministry’s 2020 *Well Child Tamariki Ora Review Report*, which highlighted the need to adopt devolved funding and commissioning arrangements in pursuing health

¹⁴ As echoed in the *Health and Disability System Reform White Paper*. DPMC 2021b, pp. 6, 9.

¹⁵ See Litmus, 2020, p. 6.

equity.¹⁶ Some DHB participants felt that in the current arrangement, too much funding is absorbed into administrative costs. Instead, funding should be divested from DHBs to such providers, in strengthening and growing “a workforce that is going to have the best accessibility to the whanau that need their support [and deliver] all those messages.” At present, DHBs have no clear policy instruction around prioritising SUDI, and devolving funding in this manner might help alleviate this, in ‘giving power’ to Māori to provide Māori solutions.

Invest in the wahakura/kairaranga sector. Demand for wahakura struggles to meet supply, and so numerous participants, from Safe Sleep Coordinators, DHBs, the EAG, and the NSPCS, have emphasised the need to support the development of this workforce. This includes building relationships with kairaranga and communities, as well as upskilling them in the basics of operating a business (GST registration, invoicing as a vendor, and so forth). At the moment the kairaranga sector needs capacity and capability building. This option achieves multiple objectives, as one kaumātua described:

“It’s actually adding a number of bolt-ons heading towards Pae Ora, including an economic development aspect, development of mātauranga, and just building confidence and experience with these māmās and babies.”

Be guided, and work in partnership, with Māori health leadership. In cases where SUDI prevention has worked well, DHBs have worked closely with Māori health leadership. This can look like:

- Having SUDI governance or steering groups with iwi/mana whenua guiding kōrero around what works best for Māori
- Having buy-in from iwi, to nurture flow-on relationships with Māori health services and providers
- Working closely with Māori health providers to see what ‘works best’ for them, and adjusting practice accordingly
- ‘Gifting’ knowledge and ISSBs to māmā and whānau, rather than ‘telling’ them what they should do regarding SUDI prevention. As one DHB participant commented,

“We don’t treat it like we’re ‘educating’ the family, what we do is we say, ‘We’re gifting these messages to you to help you keep pēpi safe.’ ... I’ve been told that Māori women don’t want to be ‘educated’... [I]t’s how you deliver those messaging [that]”

¹⁶ Ministry of Health, 2020, p. 25.

is actually really, really important, because what you're trying to do is empower them and give them strength to work through the early days of having a baby..."

One Safe Sleep Coordinator, in highlighting the need for Māori and Pasifika leadership, also called for SUDI prevention to be shifted out of the health sector:

"For me, the future [of this] space needs to be moved out of the health sector. [It] needs to set within kaupapa Māori organisations with a kaupapa Māori focus, with our Pasifika whanau sitting alongside."

Reconsider the Regional Coordinator role. There appears to be some confusion as to Regional Coordinators' roles, with some suggesting that their responsibilities more naturally sit with the NSPCS. A number of participants reported that the Regional Coordinator role is superfluous, and even some Regional Coordinators themselves felt their roles should be subsumed into a single lead entity (like the forthcoming Māori Health Authority), to avoid duplication of work, and provide a more streamlined service.

Have a centralised, coordinated approach/group for the management and dissemination of key messages, advice, and related queries. Respondents highlighted the need to improve SUDI prevention messaging, across coordination, substance, cultural appropriateness, and access. At the moment messaging appears to be ad hoc, inconsistent, and unclear, with some discussion from participants of 'going round in circles' trying to find the right person to ask about 'what the message is for X matter'. This could be due to a lack of clarity around roles and responsibilities, and would be strengthened by clarifying 'who does what'. One respondent commented that:

"I didn't know who to go to for advice to say, what is that agreed safe sleep messaging? I've googled some stuff online, I found three different things that seem to come from three reputable Ministry-funded organisations, but which one is the best? And which one is the most correct? And which one is the one that we are supposed to be using?"

This group would:

- Have SUDI clinical, kaupapa Māori, Pacific, and science communication expertise, to ensure messages are clear, easy to understand, culturally responsive, and so forth.

- Suggest appropriate ways and methods of message dissemination, i.e. through wānanga wahakura, translated into multiple languages (especially te reo and Pacific languages), etc.
- Link in to other agencies or organisations in the health, education, and welfare sector, as potential sites of message dissemination. For many participants, SUDI messaging needs to come from ‘all over’ and be repeated multiple times through multiple means. As one Safe Sleep Coordinator commented, “[T]he target focus needs to be about a safe sleep messenger and sometimes it can’t happen in one visit, but you might need to consult with a person or three times before they are actually in a space to be able to listen to it.”
- Be known in the SUDI prevention sector, with easy access so queries can be directed to them and managed accordingly.
- Emphasise the key message of ‘Every sleep must be a safe sleep’.

Improve SUDI prevention-related data access and distribution. There were numerous calls to monitor data about ISSB distribution so that the Ministry and sector more broadly are aware of how many are being distributed and to whom (Māori and Pacific whānau, for example). At present, there is a lack of data monitoring. This would contribute to an understanding of the effectiveness of the programme.

Other data-related suggestions include:

- Publishing SUDI data as soon as possible, to highlight instances where approaches are working well. One DHB, who has noted a stark drop in SUDI rates, wanted to “celebrate” their successes here.
- Gather and publish data on the effectiveness of hapū and raranga wānanga.
- Provide support to coroners to clear the backlog of cases, and quickly identify if deaths are SUDI or not, for data purposes. As one coroner explained to us, there is a delay in SUDI coronial data largely because there is a backlog of coronial decisions to be made. There are roughly 5000-6000 deaths per year, but at present only 17 coroners. This results in significant time delays.

Strengthen accountability of DHBs to the Ministry. Some respondents felt there is a disconnect between DHBs and the Ministry, with a lack of clear accountability from DHBs on SUDI prevention. This could include clear expectations around reporting requirements, in the broader goal of prioritising SUDI prevention for the DHB.

[A potential future model](#)

One EAG member suggested a new model for the NSPP that would incorporate into its design all of these areas for improvement. It is largely a summary of what has been discussed thus far, and emphasises the need for coherency and integration within the sector, as well as a unified funding investment. This participant echoed much of what was shared by those we spoke with, and we present it here as a possibility for design refresh. This model would:

- Be co-designed with Māori and Pasifika health leadership.¹⁷
- Divest funding from DHBs, and redirect the entire investment into a new, centralised, independent organisation. This agency would govern and implement NSPP and SUDI prevention-related services, and be led by Māori and Pasifika women. This organisation would oversee: strategic direction; workforce development; inter-sectoral collaboration, alignment, and cohesion; cultural competency in working with Māori, Pasifika, and priority populations; ISSB development, and distribution directly to whānau (this would include support for things like wānanga wahakura, and the raranga sector more generally); messaging and related advice, based on the suggestions above; and SUDI data collation and dissemination.
- Be grounded by Te Tiriti, tikanga, mātauranga, and kaupapa Māori, across all aspects of its design.¹⁸
- Prioritise maintaining the relationships and trust established thus far with the maternity health sector, especially with Māori providers. This is critical – there can be no disruption to these relationships, as was the case in the interval between SIDS and the NSPP, because of the negative impacts that would likely arise.
- Regional coordination of the NSPP at a local level would be done by local organisations or representatives, with standing in Māori and Pasifika communities. Each region would have a number of coordinators, with responsibility over facilitating and nourishing relationships, as well as collecting and reporting data.

Much of this aligns with the findings and recommendations of the *Health and Disability System Reform White Paper*, particularly concerning equity, partnership, Pae Ora, sustainability,¹⁹ and system leadership.²⁰ If possible, and if timing is agreeable, development of this model should be done in collaboration with the new Māori Health Authority.

¹⁷ Litmus similarly noted in their research that Māori leaders “were not involved in the design of the current WCTO programme”, and that “[n]o formal governance structures exist with Māori representation across the WTCO” (2020, p. 3). Co-design is a central aspect of this suggested model.

¹⁸ Ibid, p. 4.

¹⁹ See DPMC, 2021b.

²⁰ See DPMC, 2021a, p. 8.

KEQ 2: What is the quality of the relationships between the NSPP’s main components, and other existing maternity and child health services?

KEQ 2 examined the quality of the relationships that are nested around the main service components of the NSPP, and other existing maternity and child health services. Based on data collected, we have determined the quality of relationships between the main components delivered across NSPP and SSR services, as read through the rubric for this KEQ, is located between Te Rapunga (ineffective) and Te Whāinga (minimally effective).



Please note that much of the discussion for this KEQ is informed by the fragmented nature of the current programme and its investment modality. In general, therefore, the quality of the relationships between the NSPP’s main components, and other existing maternity and child health services, is limited. NSPP and SRS relationships are similarly largely fragmented, and lack cohesion at the service level. Further, process indicators that were not significantly present during data collection were removed from our evaluation assessment. These include:

- **Supported and activated by the appropriate leader, and at the appropriate level**
- **Seamlessly connect with the community and with other services**
- **Agile, informed, and able to be mobilised effectively**

Our rubric rating is based on the following assessment of the process indicators. The process indicators developed for this KEQ relate to identification of processes and practices that evidence high quality relationships between the NSPP’s main components and other existing maternity and child health services. Each of these are detailed below, with discussion and findings provided thereafter (some of which is repeated from KEQ1). Thus, NSPP relationships with other existing maternity and child health services should be:

- **Partnership-based between whānau Māori and providers**

Data confirms there are some relationships that are partnership-based between whānau Māori and providers. However, there is no consistent or unifying approach to partnerships across the board, due largely to the lack of intersectoral cohesion and collaboration across NSPP and SRS services. Cohesion across relationships are dependent on the tenacity and will of each service provider to engage and work with whānau. The benefits for those services who are working in partnership with Māori health leadership, and taking direction from whānau Māori, are reported positively. They are seen to be contributing to impactful outcomes for SUDI rates in the region in question. However, the lack of coordinated design means this has limited effectiveness at a national level.

We have several examples, however, of strong relationships between DHBs and kaupapa Māori health providers, Māori health leadership, or hapū and iwi, and mana whenua (in distinction from whānau Māori specifically). As one participant noted, it is critical that DHBs – as organisations – make meaningful partnerships with mana whenua/iwi/kaupapa Māori providers on issues such as maternal health, because the continuity of mana whenua means they ‘see’ the kaupapa over longer periods of time. DHB staff, by comparison, are likely to come and go. As one participant noted:

“So we acknowledge that we don’t... hold all of the knowledge and information in terms of what’s best for [these populations] so we try and help [by working with] those communities or the organisations.”

- **Strengths-based and positive**
- **Able to evidence effective working relationships across all levels of their programme**

For relationships between NSPP components, services mobilise their own interpretation of ‘what works’, resulting in a largely ad hoc approach. Critically, the focus on outputs over outcomes limits the need to work from a strengths-based and positive approach. For the most part, this fuels transactional-type relationships across the system, hampering the potential for utilising relationships and shared values to enhance service delivery across all levels of their programmes.

- **Built on a shared understanding of each others’ role and responsibilities**

There is a lack of clarity around ‘who does what’, as emphasised in KEQ1b. As one DHB participant remarked, “there is a misunderstanding about what’s happening, locally, regionally and nationally.” This leads, for example, to relationships amongst kaupapa partners and Regional Coordinators being frustrated. We heard instances of tensions when, because of this lack of clarity, DHBs would approach the NSPCS directly with

queries or issues, rather than through Regional Coordinators. (This again speaks to the importance of having clear spheres of responsibility). Similarly, some EAG members felt the Ministry's relationship with Regional Coordinators was "messy", exacerbated by the fact that their role and justification is unclear. As some participants emphasised, the programme design is not as simple as having four regional coordinators, when the complexities of the different regions means neighbouring towns or cities may approach the same issue in unique ways.

Elsewhere, some Safe Sleep Coordinators were unsure of what Regional Coordinators do, and wondered where their efforts might best be placed to support the kaupapa as a whole (as from their perspective, it was not facilitating or amplifying effectiveness of NSPP delivery). Numerous participants openly stated their preference for not having this role at all, as in one case it was seen as "not a good use of money". Instead, it was suggested their role be subsumed into services provided by the NSPCS. Some Regional Coordinators themselves shared this view, seeing coordination services as sitting more neatly with the NSPCS's ambit rather than theirs (or perhaps within the forthcoming Māori Health Authority).

Similarly, EAG and DHB respondents observed there was a need for the Ministry to provide the NSPCS with a clearer mandate of what their role is, and what they can speak into (or not). "The Ministry could do more to strengthen Hāpai's position", said one EAG member, noting also that clarified direction would give the NSPCS a more assertive position. Having clarity of roles is important across all levels of service delivery.

- **Designed and delivered to benefit whānau and configured to meet their needs**

There was insufficient data collected to measure this process indicator. Participant responses gathered indicate the intention and effort to benefit whānau, but also revealed a list of challenges around the structures and processes that impact on their ability to provide such services to whānau with diverse health needs and contexts (such as referrals, lack of cohesion in information sharing, social determinants of health, and so forth). These are well covered in previous sections of this report.

- **Enhanced by cohesive communication and actions**

The lack of programme cohesion, coupled with the absence of clear policy and supportive organisational cohesion in the programme, means the current design does not lend itself to cohesive communication and actions. This is exemplified by the unclear nature of roles and responsibilities within the NSPP, and 'who does what'. It is worth noting, however, that communication and messaging were discussed as separate – but related – actions from participants. Key messaging referred to the largely clinical or whānau-based information and messaging about best practice for

māmā and whānau related to safe sleep. By contrast, ‘communication’ denoted internal communication and connection across one service to another.

Participants commonly reported the lack of multi-level coherence about messages across the NSPP, leading to ad hoc interactions and adoption of messages at different service levels. Some also highlighted the combative clinical and cultural perspectives on what is considered important and effective for a suite of programmes like the NSPP. This tension is critical to the development of quality improvement interventions for these services, and requires a comprehensive understanding of what ‘good’ communication looks and feels like, for Māori, Pasifika and other priority populations. Participants also noted that the absence of this understanding informs and shapes services that are de-contextualised, and lacking in relevance to priority populations.

- **Resourced appropriately and valued as a strength of the programme**

In general, those we spoke with felt the disjointed nature of the design of the programme, along with a fragmented funding investment, meant there was not appropriateness of resource allocation across the NSPP. As one EAG member stated, the NSPCS, for example, receives a much smaller percentage of the budget, but, in practice, holds significant responsibility in coordinating service delivery at a national level. This, again, echoes the calls from many participants to have a more cohesive and integrated design of the NSPP – possibly divesting funding from DHBs – in more appropriately resourcing these relationships and components.

It is important to note that participants’ views on relationships were not negative or combative to good service design and delivery. There is clear evidence that effective working relationships are sought and nurtured to support and drive delivery across the main service components. What remains less clear, however, is the structural context of these services, and the way relationships are invested in: that is, at what level, and for what purpose or outcome. This is an area to explore and examine further, to understand the contexts of these services and the relationships that support them. Doing so will focus more clearly on how Māori, Pasifika and other priority populations can access and utilise services that they trust and value.

KEQ 2a: To what extent do these relationships align with the pou of Te Tiriti, Equity, Pae Ora, and ways of working?

KEQ 2b: What are the strengths and barriers of NSPP and SRS relationships, and how might we improve inter-sectoral collaboration and alignment?

As described earlier, as most participants' responses tended to gravitate towards KEQ1b, data for this KEQ2a is limited, and we have left this unanswered. Further, KEQ2b presumes a level of coherency in the current NSPP design, and as it is focussed upon improvements, this has been subsumed into KEQ 1b.

Recommendations

Key recommendations of *Kia Puawai* are detailed below:

1. Initiate a complete programme refresh of the NSPP, codesigned with Māori and Pasifika whānau and health leadership. Based on the findings in this evaluation, we suggest the refresh incorporates both national governance and local-level delivery of NSPP services into a single framework. This would include:
 - a. National governance, administered by a national entity/agency to manage and oversee the overall coordination and strategic direction of the NSPP. This agency would ensure integration of the various SUDI prevention-related services (SRS), both within the health sector (such as the WCTO ecosystem), and outside of it (such as Kāinga Ora, Oranga Tamariki, the Ministry of Education, the Ministry of Social Development, Te Puni Kōkiri, the Ministry for Pacific Peoples, and so forth), into a cohesive platform. The entity would also track progress towards Pae Ora, equity, sustainability, and so forth;^{21,22} and
 - b. Localised coordination, oversight, and delivery of SUDI prevention-related services at a community level, working in concert with the national entity. This would replace and amplify the former Regional Coordination role, and ensure the programme is grounded within the community itself, and seen as legitimate in the eyes of whānau, hapū, and iwi. Without this legitimacy and mana, the programme will see limited success. Co-design will inform how communities envision this unfolding.

This refresh should also:

- a. Be grounded by Te Tiriti o Waitangi, and kaupapa Māori and Pacific-based principles.
- b. Meaningfully demonstrate partnership by prioritising Māori and Pasifika leadership.
- c. Ensure the SUDI-prevention workforce is culturally competent and able to work appropriately with, and are acceptable to, Māori and Pasifika whānau.
- d. Reallocate all SUDI-prevention investment into the national agency, devolving the current funding arrangements to do so, to avoid the

²¹ It is possible this role could be incorporated into the forthcoming Health New Zealand or Māori Health Authority (see <https://dpmc.govt.nz/sites/default/files/2021-04/htu-factsheet-hauora-maori-en-apr21.pdf>).

²² As emphasised in the *Health and Disability System Reform: Making a stronger health and disability system for all New Zealanders*. Department of Prime Minister and Cabinet, April 2021, available at <https://dpmc.govt.nz/sites/default/files/2021-05/health-reform-white-paper-summary-easy-may21.pdf>, pp. 5-9 [DPMC, 2021b].

current fragmented nature of investment. This is to ensure contracting models are sufficient and flexible to advance equity for whānau Māori, Pasifika and other priority populations, from a centralised viewpoint. The current NSPP related service configurations are not congruent with government direction and policy guidance for Te Tiriti.

- e. Disestablish the Regional Coordinator roles as they currently are, in giving way to this new model.
 - f. Remain whānau-centric, to ensure care is person- and whānau-centred, and be integrated into grassroots communities (through churches, marae, schools, Kōhanga Reo, Kura Kaupapa, Wharekura, etc.).
 - g. Clearly communicate the new roles and responsibilities of the refreshed NSPP to the health and related sectors, so everyone knows ‘who does what’.
 - h. Improve, strengthen, and streamline SUDI-related data access and distribution.
2. Prioritise the continued maintenance of relationships and trust established thus far with the maternity health sector, especially with Māori providers, as the refresh proceeds. This is critical – there can be no disruption to these relationships, as was the case in the interval between SIDS and the NSPP, because of the negative impacts that would likely arise.
 3. Have a centralised, coordinated approach for the management and dissemination of key messages, advice, and related SUDI-prevention queries. This would sit within the centralised entity, and be based on the principles outlined on pp. 36-7.

Appendix 1: Evaluation Framework

PROCESS KEQs	MEASURE/GOAL	PROCESS INDICATORS	DATA SOURCE
<p>KEQ 1: To what extent does the content, design, and delivery of NSPP and SUDI prevention-related services (SRSs) meet the needs of Māori, Pasifika, and other priority populations?</p>	<p>Māori, Pasifika, and other priority populations are receiving (accessing and engaging) NSPP and SRSs that meet their needs</p>	<p>TE TIRITI</p> <p>The NSPP and SRSs provide services in a way that:</p> <ul style="list-style-type: none"> • Are based on, and delivered within, mātauranga Māori and tikanga Māori, and particularly on kaupapa Māori concepts of tamariki Māori health and wellbeing within the context of whānau²³ • Partner with Māori leadership and stewardship²⁴ • Supports tino rangatiratanga and mana motuhake within child and maternal health²⁵ • Are flexible, whānau-centred, and build whānau capacity²⁶ • Actively demonstrate their commitment (Leadership and Actions across all layer of their programme) to achieving equitable outcomes for Māori • Demonstrates they understand the importance of outcomes and the direction and distribution of efforts required to achieve equity for Māori, Pasifika, and other priority populations • Resources kaupapa Māori services to achieve 	<ul style="list-style-type: none"> • Interviews • Numbers of Māori, Pasifika and other priority population whānau receiving ISSBs of choice • Numbers of whānau using wahakura or Pēpipod • Whānau/provider narratives about the value, usability, and appropriateness of the education and guidelines (e.g., wānanga) • Number of wāhine supported to quit smoking during pregnancy • Whānau/provider narratives about smoke-free messaging • Whānau/provider narratives about the risks of smoke exposure for SUDI • Number of wāhine supported to address drug/alcohol issues during pregnancy and in post-natal period

²³ This is adapted from Litmus' 2020 *Key insights from whānau Māori research and literature to inform the WCTO programme review*, available at <https://www.health.govt.nz/system/files/documents/publications/key-insights-whanau-maori-research-literature-inform-wcto-programme-review.pdf>.

²⁴ Ibid.

²⁵ Ibid.

²⁶ Ibid.

PROCESS KEQs	MEASURE/GOAL	PROCESS INDICATORS		DATA SOURCE
			<p>equity across all levels of the programme²⁷</p> <ul style="list-style-type: none"> • Are designed and informed by Māori with lived experience and insights with SUDI 	
		<i>EQUITY</i>	<ul style="list-style-type: none"> • Demonstrates they understand the importance of outcomes and the direction of efforts required to achieve equity • Resource kaupapa Maori services to achieve equity across all levels of the programme • Is equitable for Māori, Pasifika, and other priority populations • Demonstrates evidence of equitable distribution of resources and funding at across all levels of the programme 	
		<i>PAE ORA</i>	<ul style="list-style-type: none"> • Support whānau to express and achieve their aspirations for their tamariki. • Support aspirations for Pae Ora for our Māori, Pasifika, and other priority populations. • Utilise Ministry and government strategic levers to inform, align and activate responses for Māori, Pasifika, and other priority populations 	

²⁷ Ibid.

PROCESS KEQs	MEASURE/GOAL	PROCESS INDICATORS	DATA SOURCE
<p>KEQ 1a: In what ways are whānau Māori and ‘āiga Pasifika supported to access, engage, and utilise NSPP services and SRSs?</p>	<p>Māori, Pasifika, and other priority populations are receiving (accessing and engaging) NSPP services and SRSs that meet their needs</p>	<p>The NSPP and SRSs provide services in a way that:</p> <ul style="list-style-type: none"> • Are culturally safe²⁸ • Are whānau-centred and strengths-based²⁹ • Builds whānau capability and he māia (the courage to parent as Māori)³⁰ • Enable access and support ongoing engagement of Māori, Pasifika, and priority populations with the programme³¹ • Supports the uptake and reach to Māori and Pasifika whānau • Promotes clear, credible and consistent messaging • Relevant to Māori and Pasifika contexts and experiences • Relate and connect to Māori and Pasifika experiences • Are informed and shaped by relatable narratives around Māori and Pasifika child and maternal health • Identify multiple pathways (options) and links to related child and maternal health services (e.g., smoking, etc.) • Resonates with how Māori and Pasifika whānau want to be engaged (co-design etc.) 	<ul style="list-style-type: none"> • Interviews • Numbers of Māori and Pasifika whānau receiving ISSBs of choice • Whānau/provider narratives about the value, usability, and appropriateness of the education and guidelines (e.g., wānanga) • Number of wāhine supported to quit smoking during pregnancy • Whānau/provider narratives about smoke-free messaging • Whānau/provider narratives about the risks of smoke exposure for SUDI • Number of wāhine supported to address drug/alcohol issues during pregnancy and in post-natal period

²⁸ Ibid.

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

PROCESS KEQs	MEASURE/GOAL		PROCESS INDICATORS	DATA SOURCE
<p>KEQ 1b: What is working well, for whom and in what ways? What can be improved?</p>		<p><i>FORMATIVE FOCUS</i></p>	<p>How can the NSPP and SRSs be improved to better realise the above indicators?</p> <ul style="list-style-type: none"> • Programme messaging is presented in a range of ways to meet the diverse needs of mothers and whānau • Programme documentation is accurate and regularly updated • Programme initiatives, outputs and outcomes are being delivered as intended and to budget (Efficiency-effectiveness) • Equity focus is evident across the resources and investments of the programme • Programme initiatives are impacting positively on key groups (Relevance) • Programme initiatives are influencing and strengthening collaboration (Supporting access and engagement) • Referral pathways and opportunities identified • Service enablers identified and incorporated in programme design • Obstacles to service delivery identified, with opportunities for mitigation • Continuous quality improvement cycles are evident 	<p>Interviews</p>

PROCESS KEQs	MEASURE/GOAL	PROCESS INDICATORS	DATA SOURCE
<p>KEQ 2: What is the quality of the relationships between the NSPP’s main components, and other existing maternity and child health services?</p>	<p>The NSPP’s main components are cohesively working and collaborating with other existing maternity and child health services to better deliver services</p>	<p>NSPP relationships with other existing maternity and child health services are:</p> <ul style="list-style-type: none"> • Partnership-based between whānau Māori and providers³² • Strengths-based and positive • Built on a shared understanding of each others’ role and responsibilities • Able to evidence effective working relationships across all levels of their programme • Supported and activated by the appropriate leader, and at the appropriate level • Agile, informed, and able to be mobilised effectively • Designed and delivered to benefit whānau and configured to meet their needs • Seamlessly connecting with the community and with other services³³ • Enhanced by cohesive communication and actions • Resourced appropriately and valued as a strength of the programme 	<p>Interviews</p>
<p>KEQ 2a: To what extent do these relationships align with the pou of Te Tiriti, Equity, Pae Ora, and ways of working?</p>		<p>TE TIRITI</p> <p>Together, these relationships:</p> <ul style="list-style-type: none"> • Support tino rangatiratanga and mana motuhake within child and maternal health • Actively demonstrate their commitment (Leadership and Actions across all layer of their programme) to achieving equitable outcomes for Maori 	<p>Interviews</p>

³² Ibid.

³³ Ibid.

PROCESS KEQs	MEASURE/GOAL	PROCESS INDICATORS	DATA SOURCE
		<ul style="list-style-type: none"> • Demonstrate they understand the importance of outcomes and the direction and distribution of efforts required to achieve equity for Māori, Pasifika, and other priority • Resource kaupapa Māori services to achieve equity across all levels of the programme • Are designed and informed by Māori with lived experience and insights with SUDI 	
		<p><i>EQUITY</i></p> <ul style="list-style-type: none"> • Demonstrate they understand the importance of outcomes and the direction of efforts required to achieve equity • Resource kaupapa Māori services to achieve equity across all levels of the programme • Are equitable for Māori, Pasifika, and other priority populations • Demonstrate evidence of equitable distribution of resources and funding across all levels of the programme 	Interviews
		<p><i>PAE ORA</i></p> <ul style="list-style-type: none"> • Support whanau to express and achieve their aspirations for their tamariki. • Support aspirations for Pae Ora for our Māori, Pasifika, and other priority populations. • Utilise Ministry and government strategic levers to inform, align and activate responses for Māori, Pasifika, and other priority populations 	Interviews
		<p><i>WAYS OF WORKING</i></p> <ul style="list-style-type: none"> • Exemplify the following values and ethics of engagement: <ul style="list-style-type: none"> ○ Manaakitanga: care, inclusion, respect, support, trust and kindness ○ Kaitiakitanga: preservation and maintenance of an 	Interviews

PROCESS KEQs	MEASURE/GOAL	PROCESS INDICATORS		DATA SOURCE
			<p>environment that enables people to thrive</p> <ul style="list-style-type: none"> ○ Whakapono: trust and faith in each other ○ Kōkiri ngātahi: working together towards a common purpose 	
<p>KEQ 2b: What are the strengths and barriers of NSPP and SRS relationships, and how might we improve inter-sectoral collaboration and alignment?</p>		<p><i>FORMATIVE FOCUS</i></p>	<p>How can the NSPP and SRSs be improved to better realise the above indicators?</p> <ul style="list-style-type: none"> ● Strengths and barriers identified, analysed and addressed ● Continuous quality improvement cycles are evident ● Communication channels and feedback loops are evident ● Active leadership and responses for priority population groups are evident 	<p>Interviews</p>

CONSOLIDATED INTERVIEW SCHEDULE

KEQ 1: To what extent does the content, design, and delivery of NSPP and SUDI prevention-related services (SRSs) meet the needs of Māori, Pasifika, and other priority populations?

1. Can you tell us about your role and the types of activities you provide?
2. Thinking about those activities, how would you describe the inclusion of mātauranga Māori and tikanga Māori?
3. In your experience, how are the concepts of kaupapa Māori woven into Māori health and wellbeing within the context of this service?
4. Do you have any partnerships with Māori health leadership that support this? Who, when, and how often?
5. What does tino rangatiratanga and mana motuhake, within child and maternal health, mean to you? How are these values supported in your service?
6. Would you describe your services as flexible, whānau-centred, and supportive for whanau Maori, Pasifika, and other priority populations? Why/why not?
7. In what ways do you demonstrate your commitment (Leadership and Actions across all layers of their programme) to achieving equitable outcomes for Māori? Tell me about your experience and journey with this commitment.
8. What are some of the primary actions in your service for achieving equity for Māori, Pasifika, and other priority populations?
 - Overall, is the direction and distribution of effort for equity enough?
 - What levels of this service/role need attention to achieve or improve efforts for equity?
 - Can you describe the resourcing levels across each of the components in this service?
9. In your opinion are these services designed and informed by Māori with lived experience and insights with SUDI? [Probe ‘How’, ‘In what ways’? etc]
10. In the context of your role, and through this service, how well do you think whānau are supported to express and achieve their aspirations for their tamariki?
11. In the context of your role, and through this service, how well do you think the aspirations for Pae Ora for Māori, Pasifika, and other priority populations are developing? [Probe – Barriers, enablers]
12. In the context of your role, and through this service, how well do you think the Ministry and government strategic levers (*What are these – need to have these on hand to share with them IF they need prompting*) are being activated/developed/progressed?

KEQ 1a: In what ways are whānau Māori and ‘āiga Pasifika supported to access, engage, and utilise NSPP services and SRSs?

1. Can you tell us about your role and the types of activities you provide?
2. How would you describe your approach to being a service that is:
 - Culturally safe
 - Whānau-centred
 - Strengths-based
3. In what ways does the service build whānau capability and he māia (the courage to parent as Māori)?
4. Taking a long term view of the service, how might we enable access and support ongoing engagement of Māori, Pasifika, and priority populations with the programme? [Probe – experiences, barriers and enablers to increasing access and support]
5. In your experience, what type of activities support the uptake and reach of this service to Māori and Pasifika whānau? [Probe – How is that working? Who does this? How often? When and why?] **EXEMPLARS** – *Who's doing it really well at the moment?*
6. Overall, how well do you think this service promotes clear, credible and consistent messaging to whānau Māori, Pasifika, and other priority populations?
7. In your experience are/do those messages contain information that is:
 - Relevant to Māori and Pasifika contexts and experiences
 - Relatable to, and informed by, Māori and Pasifika experiences and narratives around Māori and Pasifika child and maternal health
 - Replete with multiple pathways (options) and links to related child and maternal health services (e.g., smoking, etc.)
 - Resonant with how Māori and Pasifika whānau want to be engaged (co-design etc.)

KEQ1b: What is working well, for whom and in what ways? What can be improved?

1. Thinking about the service objectives of the role do you think programme messaging is presented in a range of ways to meet the diverse needs of mothers and whanau? Why/Why not? How/in what ways?
2. How often is programme documentation reviewed? Are they accurate and regularly updated? Can you describe the approach of a recent review or update for this service?
3. Overall, do you think the programme initiatives, outputs and outcomes are being delivered as intended and to budget? (Efficiency-effectiveness)
4. In your experience of this role/service, how would you rate the Equity focus for this service? [Probe resources and investments of the programme].
5. Do you think the resources, and investments at the programme level are;
 - Impacting positively on key groups (Relevance)

- Influencing and strengthening collaboration (Supporting access and engagement)
6. Thinking about a continuous quality improvement cycle, how often are
- Referral pathways and opportunities identified?
 - Service enablers identified and incorporated in programme design?
 - Obstacles to service delivery identified, with opportunities for mitigation identified?

KEQ 2: What is the quality of the relationships between the NSPP’s main components, and other existing maternity and child health services?

1. How would you describe your relationship with other existing maternity and child health services?
 - Would you describe this as effective? If so, how? If not, why so?
 - Is it agile? Is the right leader involved at the right time, to facilitate these relationships?
2. Do you have a clear understanding of what other existing maternity and child health services do, and are responsible for?
3. How would you describe the flow of communication between you/your organisation and other maternity and child health services?
 - Is it cohesive or clashing?
 - Is the communication pipeline across the services designed and delivered to benefit whānau?
 - What guides and informs the approach to cohesive communication? [Probe: Strengths and Challenges, action plans, communication etc]
4. How would you describe the relationship between providers in the maternity and child health landscape, and whānau Māori?
5. Do you think the quality of relationships are resourced appropriately? [Effort, energy and resource]
6. Are these relationships and the work involved with them viewed as a strength or a challenge?
7. What are some of the challenges that impact on these relationships? How, and in what ways?

KEQ 2a: To what extent do these relationships align with the pou of Te Tiriti, Equity, Pae Ora, and ways of working?

Te Tiriti

1. In what ways do you think the relationships you have now [with maternity and child health services] contribute to: a. Te Tiriti?
 - i. What would you build/bust/buy to enhance these relationships, and better achieve these aspirations for Te Tiriti?
2. In what ways do you think the relationships you have now contribute to the aspirations outlined in Te Tiriti?

3. How and in what ways do the relationships support tino rangatiratanga and mana motuhake within child and maternal health?
4. In general, how are the leadership roles and actions of this service contributing to achieving equitable outcomes for Māori? Who contributes to the 'lift'? [Probe: Direction and distribution of effort, across all layers of the service/programme. How/in what ways - Describe those to us?]
5. How and in what ways does this service contribute to Te Tiriti?
6. Thinking about these relationships, how might/how does this service activate the strategic intent of the actions underpinned in Te Tiriti? [Probe Examples, Reflections on practice]
7. What does AWESOME look like for these relationships if we are activating Ngā Pou in our sector relationships?

Equity

1. In what ways do you think the relationships you have now [with maternity and child health services] contribute to: a. Equity?
 - i. What would you build/bust/buy to enhance these relationships, and better achieve these aspirations for Equity?
2. In general, how are the leadership roles and actions of this service contributing to achieving equitable outcomes for Māori? Who contributes to the 'lift' ? [Probe: Direction and distribution of effort, across all layers of the service/programme. How/In what ways - Describe those to us?]
3. How and in what ways does this service contribute to equity?
4. Thinking about the relationships, how might/how does this service activate the strategic intent of the actions underpinned in equity? [Probe: Examples, Reflections on practice]
5. Would you describe this approach as equitable for Māori, Pasifika and other priority populations?
6. Describe the way in which the distribution of resources and funding is allocated? To whom, when and in what ways?

Pae Ora

1. Overall, how are the leadership roles and actions of this service contributing to Pae Ora for Māori ? Who contributes to the 'lift'? [Probe: direction and distribution of effort, across all layers of the service/programme. How/In what ways - Describe those to us?]
2. Thinking about these relationships, how might/how does this service activate the strategic intent of the actions underpinned in Pae Ora? [Probe: Examples, Reflections on practice]
3. Would you describe this approach as being supportive of whānau to express and achieve their aspirations for their tamariki?
4. Can you describe the way in which relationships inform and support aspirations for Pae Ora for our Māori, Pasifika, and other priority populations?

5. Overall, how well do the current configuration of relationships utilise Ministry and government strategic levers to inform, align and activate responses for Māori, Pasifika, and other priority populations? [Probe: convergence, divergent ways of working, intra-sectoral service integration etc]

Ways of Working

1. How would you describe your ways of working/engagement with other maternity and child health services?
2. What values would you use to describe these relationships?
3. How familiar are you with the values and ethics of engagement as outlined in Ngā Pou?

KEQ 2b: What are the strengths and barriers of NSPP and SRS relationships, and how might we improve inter-sectoral collaboration and alignment?

1. What are the strengths and barriers of the relationships between your organisation [as a component of the NSPP] and other maternity and child services?
 - a. What would you build/bust/buy to enhance and improve these relationships?

INTERVIEW SCHEDULE: DHB PORTFOLIO MANAGERS

1. Can you tell us about your role and the types of initiatives you oversee in the DHB?
2. Thinking about those initiatives, how would you describe the inclusion of mātauranga Māori and tikanga Māori? Partnerships with Maori etc Who, when, etc
3. What are some of the primary actions in your service for achieving equity for Māori, Pasifika, and other priority populations?
 - Overall, is the direction and distribution of effort for equity enough?
 - What levels of this service/role need attention to achieve or improve efforts for equity?
 - Can you describe the resourcing levels across each of the components in this service?

KEQ1b: What is working well, for whom and in what ways? What can be improved?

1. Overall, do you think the programme initiatives, outputs and outcomes are being delivered as intended and to budget? (Efficiency-effectiveness)
2. Describe the way in which the distribution of resources and funding is allocated? To whom, when and in what ways?
3. Do you think the resources, and investments at the programme level are;
 - Impacting positively on key groups (Relevance)
 - Influencing and strengthening collaboration (Supporting access and engagement)

KEQ 2: What is the quality of the relationships between the NSPP's main components, and other existing maternity and child health services?

1. How would you describe your relationship with other existing maternity and child health services?
 - Would you describe this as effective? If so, how? If not, why so?
 - Is it agile? Is the right leader involved at the right time, to facilitate these relationships?
2. How would you describe the flow of communication between you/your organisation and other maternity and child health services?
 - Is it cohesive or clashing?
 - Is the communication pipeline across the services designed and delivered to benefit whānau?
 - What guides and informs the approach to cohesive communication? [Probe: Strengths and Challenges, action plans, communication etc]

3. How would you describe the relationship between providers in the maternity and child health landscape, and whānau Māori? What values would you use to describe those relationships ?

4. Do you think the quality of relationships are resourced appropriately? [Effort, energy and resource]

5. Are these relationships and the work involved with them viewed as a strength or a challenge?

6. What are some of the challenges that impact on these relationships? How, and in what ways?

KEQ 2a: To what extent do these relationships align with the pou of Te Tiriti, Equity, Pae Ora, and ways of working?

1. In the context of your role how familiar are you with the values and ethics of engagement as outlined in Nga Pou. As the aspirations for this kaupapa/this initiative how well do you think this DHB is tracking or working towards these values and ethics of engagement? (Probe: Why, How and in What ways?)

2. In what ways do you think the relationships you have now [with maternity and child health services] contribute to:

- Te Tiriti
- Equity
- Pae Ora
- Ways of working

3. What would you build/bust/buy to enhance these relationships, and better achieve these aspirations for ;

- Te Tiriti
- Equity,
- Pae Ora and
- Ways of working

4. How and in what ways do the relationships support tino rangatiratanga and mana motuhake within child and maternal health?

5. How and in what ways does this DHB contribute to Te Tiriti, Equity, Pae Ora and Ways of working ? Who contributes to the 'lift' of Te Tiriti, Equity, Pae Ora and Ways of working? [Probe: direction and distribution of effort, leadership roles across the service/In what ways - Describe those to us?]

KEQ 2b: What are the strengths and barriers of NSPP and SRS relationships, and how might we improve inter-sectoral collaboration and alignment?

1. What are the strengths and barriers of the relationships between your organisation [as a component of the NSPP] and other maternity and child services?
 - 1a. What would you build/bust/buy to enhance and improve these relationships? OR Departure – Destination – Where do you want to see this sector ? What things would you leave behind?

**INTERVIEW SCHEDULE: REGIONAL COORDINATORS & SAFE SLEEP
COORDINATORS**

KEQ 1: To what extent does the content, design, and delivery of NSPP and SUDI prevention-related services (SRSs) meet the needs of Māori, Pasifika, and other priority populations?

1. Can you tell us about your role and the types of activities you provide?
2. How would you describe your approach to being a service that is:
 - Culturally safe
 - Whānau-centred
 - Strengths-based
3. Thinking about those activities, how would you describe the inclusion of mātauranga Māori and tikanga Māori?
4. Do you have any partnerships with Māori health leadership that support this? Who, when, and how often?
5. What are some of the primary actions in your service for achieving equity for Māori, Pasifika, and other priority populations?
 - Overall, is the direction and distribution of effort for equity enough?
 - What levels of this service/role need attention to achieve or improve efforts for equity?
 - Can you describe the resourcing levels across each of the components in this service?
6. Taking a long-term view of the service, how might we enable access, support and ongoing engagement with whānau Māori and aiga Pasifika? [Probe – experiences, barriers and enablers to increasing access and support]
7. Overall, how well do you think this service promotes clear, credible and consistent messaging to whānau Māori and aiga Pasifika?
8. In your experience are/do those messages contain information that is:
 - Relevant to Māori and Pasifika contexts and experiences
 - Relatable to, and informed by, Māori and Pasifika experiences and narratives around Māori and Pasifika child and maternal health
 - Replete with multiple pathways (options) and links to related child and maternal health services (e.g., smoking, etc.)
 - Resonant with how Māori and Pasifika whānau want to be engaged (co-design etc.)

KEQ1b: What is working well, for whom and in what ways? What can be improved?

1. Thinking about the service objectives of the role do you think programme messaging is presented in a range of ways to meet the diverse needs of mothers and whānau? Why/Why not? How/in what ways?

2. How often is programme documentation reviewed? Are they accurate and regularly updated? Can you describe the approach of a recent review or update for this service?
3. Overall, do you think the programme initiatives, outputs and outcomes are being delivered as intended and to budget? (Efficiency-effectiveness)
4. In your experience of this role/service, how would you rate the Equity focus for this service? Probe resources and investments of the programme
5. Do you think the resources, and investments at the programme level are;
 - Impacting positively on key groups (Relevance)
 - Influencing and strengthening collaboration (Supporting access and engagement)
6. Thinking about a continuous quality improvement cycle, how often are
 - Referral pathways and opportunities identified?
 - Service enablers identified and incorporated in programme design?
 - Obstacles to service delivery identified, with opportunities for mitigation identified?

KEQ 2: What is the quality of the relationships between the NSPP’s main components, and other existing maternity and child health services?

1. How would you describe your relationship with other existing maternity and child health services? Would you describe this as effective? If so, how? If not, why so? Is the right leader involved at the right time, to facilitate these relationships?
2. Do you have a clear understanding of what other existing maternity and child health services do, and are responsible for?
3. How would you describe the flow of communication between you/your organisation and other maternity and child health services?
 - Is it cohesive or clashing? [Probe: Strengths and Challenges, action plans, communication etc]
4. How would you describe the relationship between providers in the maternity and child health landscape, and whānau Māori?
5. Do you think the quality of relationships are resourced appropriately? [Effort, energy and resource]
6. Are these relationships and the work involved with them viewed as a strength or a challenge?
7. What are some of the challenges that impact on these relationships? How, and in what ways?

KEQ 2a: To what extent do these relationships align with the pou of Te Tiriti, Equity, Pae Ora, and ways of working?

Te Tiriti

1. In what ways do you think the relationships you have now [with maternity and child health services] contribute to:
 - Te Tiriti?

- What would you build/bust/buy to enhance these relationships, and better achieve these aspirations for Te Tiriti?
2. In what ways do you think the relationships you have now contribute to the aspirations outlined in Te Tiriti?
 3. How and in what ways do the relationships support tino rangatiratanga and mana motuhake within child and maternal health?
 4. In general, how are the leadership roles and actions of this service contributing to achieving equitable outcomes for Māori? Who contributes to the 'lift'? [Probe: Direction and distribution of effort, across all layers of the service/programme. How/in what ways - Describe those to us?]
 5. How and in what ways does this service contribute to Te Tiriti?
 6. Thinking about these relationships, how might/how does this service activate the strategic intent of the actions underpinned in Te Tiriti? [Probe Examples, Reflections on practice]
 7. What does AWESOME look like for these relationships if we are activating Ngā Pou in our sector relationships?

Equity

In what ways do you think the relationships you have now [with maternity and child health services] contribute to:

- Equity?
 - What would you build/bust/buy to enhance these relationships, and better achieve these aspirations for Equity?
2. In general, how are the leadership roles and actions of this service contributing to achieving equitable outcomes for Māori? Who contributes to the 'lift' ? [Probe: Direction and distribution of effort, across all layers of the service/programme. How/In what ways - Describe those to us?]
 3. How and in what ways does this service contribute to equity?
 4. Thinking about the relationships, how might/how does this service activate the strategic intent of the actions underpinned in equity? [Probe: Examples, Reflections on practice]
 5. Would you describe this approach as equitable for Māori, Pasifika and other priority populations?
 6. Describe the way in which the distribution of resources and funding is allocated? To whom, when and in what ways?

Pae Ora

1. Overall, how are the leadership roles and actions of this service contributing to Pae Ora for Māori? Who contributes to the 'lift'? [Probe: direction and distribution of effort. How/In what ways - Describe those to us?]
2. Thinking about these relationships, how might/how does this service activate the strategic intent of the actions underpinned in Pae Ora? [Probe: Examples, Reflections on practice]

3. Would you describe this approach as being supportive of whānau to express and achieve their aspirations for their tamariki?
4. Can you describe the way in which relationships inform and support aspirations for Pae Ora for our Māori, Pasifika, and other priority populations?
5. Overall, how well do the current configuration of relationships utilise Ministry and government strategic levers to inform, align and activate responses for Māori, Pasifika, and other priority populations? [Probe: convergence, divergent ways of working, intra-sectoral service integration etc]

Ways of Working

1. How familiar are you with the values and ethics of engagement as outlined in Ngā Pou?
2. How would you describe your ways of working/engagement with other maternity and child health services?
3. What values would you use to describe these relationships?

KEQ 2b: What are the strengths and barriers of NSPP and SRS relationships, and how might we improve inter-sectoral collaboration and alignment?

1. What are the strengths and barriers of the relationships between your organisation [as a component of the NSPP] and other maternity and child services?
 - 1a. What would you build/bust/buy to enhance and improve these relationships?

INTERVIEW SCHEDULE: EXPERT ADVISORY GROUP

1. Can you tell us about your role and the types of areas you provide advice and guidance on?
2. In your experience, how are the actions of this kaupapa (Advisory group) contributing towards equitable outcomes for whānau and aiga?
3. In your opinion what are the strengths and challenges of the advisory group?
4. What are some of the issues and concerns that have been brought to your attention of the advisory group?
5. In the context of NSPP, how would you describe the mahi that is being designed and delivered across DHBs? Where do you think it is being done well ? In what ways and why?
6. To what extent do you think the services of NSPP are flexible, whānau - centred, and supportive for Māori, Pasifika, and other priority populations? Why/why not?
7. In your opinion are SUDI prevention services designed and informed by Māori and Pasifika with lived experience and insights with SUDI? [Probe 'How', 'In what ways'? etc]
8. Would you describe this approach as being supportive of whānau to express and achieve their aspirations for their tamariki?
9. Taking a long-term view of the kaupapa (NSPP – SUDI prevention services), how might we enable access, support and ongoing engagement of Māori, Pasifika, and priority populations with the programme? [Probe – experiences, barriers and enablers to increasing access and support]
10. In your experience, what type of activities support the uptake and reach of SUDI prevention services to whānau and aiga? [Probe – How is that working? Who does this? How often? When and why?] **EXEMPLARS** – *Who's doing it really well at the moment?*
11. What is your understanding of the relationships between SUDI prevention providers and other maternity and child health services?
12. Are these relationships viewed as a strength or a challenge?
13. What are some of the strengths and barriers that impact on these relationships? How, and in what ways?
14. What would you build/bust/buy to enhance this kaupapa?

Appendix 3: Reach out emails

INITIAL REACH OUT EMAIL

Tēna koe _____
Nei rā te mihi ki a koe, e ū pono ana ki tēnei kaupapa – National Sudden Unexpected Death in Infants Prevention Programme.
Ko te manako ia kei te noho haumarua koe. Me haumarua tonu te noho.
Me mihi hoki ki a tātou kua wheturangihia – koutou e noho āio ana ki te poho o Ranginui, hāere, hāere, hāere atu ra.
Hoki mai ana ki a tātou e hikoi ana i te mata o te whenua,
Mauri ora ki a tātou.
Huri noa,
Tēna koe,
A, tēna rā tatou katoa.

We hope this email finds you and yours well. The warmer brighter days indeed give cause for celebrating this gift that is life.

With the recent change in Alert levels it also seemed a good idea to connect and link in with our kaupapa partners for this evaluation.

Purpose of our engagement

This email in the first instance is to invoke a sense of connection and purpose to the evaluation mahi we are undertaking in this sector.

The service innovation and journey travelled so far has inspired us and we look forward to walking alongside providers in this evaluation.

Our evaluation combines both process and formative components, and will evaluate the delivery and effectiveness of the various components of the National Sudden Unexpected Deaths in Infants Prevention Programme and its inter-sectoral linkages and integration. It seeks to identify improvements for the programme, as an integrated component of the wider maternity and child health landscape, and how better to address the continued inequity in Sudden Unexpected Death in Infant rates experienced by Māori and Pasifika peoples.

Your insights and experiences through your respective roles are critical to building a credible assessment of the efficacy and effectiveness of the mahi evolving in this space. The evaluation we are undertaking has a strong Māori and Pasifika lens and we will be asking about the way services integrate *Ngā Pou (Te Tiriti, Achieving Equity, Pae Ora)* and ensure an equity lens is applied across the service.

We look forward to capturing your voice as part of a shared journey to improve Māori and Pasifika outcomes overall. We expect interviews will take 20-30 minutes depending on what you have to say and there are options on the medium e.g. online, phone call, face to face (when and as appropriate)
We have put together some documents that canvas how we wish to shape the journey and surface guiding protocols to support the mahi over the life course of the evaluation. Our process is grounded and guided by Kaupapa Māori and we share that responsibility as kaupapa partners in this evaluation.

Documents attached include:

- Team presentation
- Information Sheet
- Consent form
- Our approach to kaupapa Māori evaluation

These documents should give you a sense of how we can shape our 'Hikoi' and identify a way of working together to maximise the insights and learnings for NSPP. As kaupapa Māori evaluators, it is our privilege to capture these stories and share them back alongside you all.

Please contact me if you have any questions, we are happy to share where our thoughts are and next steps to gearing up for our Hikoi in the evaluation. Within the current situation, we are formulating a plan for how this mahi might be progressed across the various Alert levels. We will update this with you once this has been finalised.

Nga manaakitanga
Rianna Greaves – Project Co-Ordinator, Te Werohau

FOLLOW-UP EMAIL

Tēna koe _____,

Nei te mihi āno ki a koe me tō ngākau nui ki te kaupapa National Unexpected Death in Infants Prevention Programme.

I hope you and your whānau are keeping warm and well in this unpredictable spring weather.

The purpose of this email is to engage your participation in the evaluation of the National SUDI Prevention Programme.

We sent a direct reach out to the sector last week and this is our gentle reminder and check in email to ensure we have engaged the sector.

Your professional insight and voice for this kaupapa is important to us.

We have a team of evaluators who are available to capture your insights and options for how we can undertake your interview.

Phone, Zoom or teams based interviews are available. In some cases, a face to face is available however due to covid this will be on a case by case basis, and dependent upon the evaluators availability (eg, proximity, time).

Can I ask that you please reply to this email with your preferred option for the interview, and a range of times that will work for your calendar. Our team will meet the time and date that works for you.

Due to the tight timeframe of our evaluation – I will follow up with a phone call tomorrow afternoon (Friday 17/09/21) and on Monday (20/9/21).

Look forward to hearing from you soon or talking with you (whatever arrives first).

Nga mihi in advance,

Rianna Greaves

Project Co-Ordinator – Te Werohau